HOUSE OF COMMONS SESSION 1999–2000

HEALTH COMMITTEE

Second Report

THE TOBACCO INDUSTRY AND THE HEALTH RISKS OF SMOKING

Volume I

Report and Proceedings of the Committee

Ordered by The House of Commons *to be printed*
5 June 2000

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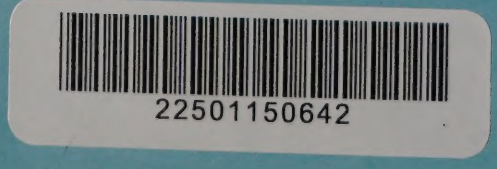

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The Health Committee is appointed to examine on behalf of the House of Commons the expenditure, administration and policy of the Department of Health (and any associated public bodies). Its constitution and powers are set out in House of Commons Standing Order No. 152.

The Committee has a maximum of eleven members, of whom the quorum for any formal proceedings is three. The members of the Committee are appointed by the House and unless discharged remain on the Committee until the next dissolution of Parliament. The present membership of the Committee is as follows:[1]

Mr David Amess MP (*Conservative, Southend West*)[2]
Mr John Austin MP (*Labour, Erith and Thamesmead*)
Dr Peter Brand MP (*Liberal Democrat, Isle of Wight*)
Mr Simon Burns MP (*Conservative, Chelmsford West*)[3]
Mrs Eileen Gordon MP (*Labour, Romford*)[4]
Mr John Gunnell MP (*Labour, Morley and Rothwell*)
Mr Stephen Hesford MP (*labour, Wirral West*)[5]
Mr David Hinchliffe MP (*Labour, Wakefield*)
Dr Howard Stoate MP (*Labour, Dartford*)
Mr Robert Syms MP (*Conservative, Poole*)
Audrey Wise MP (*Labour, Preston*)

On 17 July 1997, the Committee elected *Mr David Hinchliffe* as its Chairman.

The Committee has the power to require the submission of written evidence and documents, to send for and examine witnesses, and to make Reports to the House. In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, references to the written evidence are indicated by 'Ev' followed by a page number.

The Committee may meet at any time (except when Parliament is prorogued or dissolved) and at any place within the United Kingdom. The Committee may meet concurrently with other committees or sub-committees established under Standing Order No. 152 and with the House's European Scrutiny Committee (or any of its sub-committees) for the purpose of deliberating, taking evidence or considering draft reports. The Committee may exchange documents and evidence with any of these committees, as well as with the House's Public Accounts, Deregulation and Environmental Audit committees.

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/commons/hsecom/htm A list of Reports of the Committee in the present Parliament is at the end of this volume.

All correspondence should be addressed to The Clerk of the Health Committee, Committee Office, House of Commons, London SW1A 0AA. The telephone number for general inquiries is: 020 7219 5466; the Committee's e-mail address is healthcom@parliament.uk.

[1] Rt Hon Peter Brooke MP *(Conservative, Cities of London and Westminster)*, was appointed on 14 July 1997 and discharged on 21 July 1997; Mr Andrew Lansley MP *(Conservative, Cambridgeshire South)*, was appointed on 14 July 1997 and discharged on 20 July 1998; Ann Keen MP *(Labour, Brentford and Isleworth)*, was appointed on 14 July 1997 and discharged on 1 February 1999; Mr Robert Walter MP *(Conservative, Dorset North)*, was appointed on 14 July 1997 and discharged on 5 July 1999; Julia Drown MP *(Labour, Swindon South)*, was appointed on 14 July 1997 and discharged on 30 November 1999; Mr Ivan Lewis MP *(Labour, Bury South)*, was appointed on 1 February 1999 and discharged on 13 December 1999.
[2] Appointed 20 July 1998.
[3] Appointed 5 July 1999.
[4] Appointed 30 November 1999.
[5] Appointed 13 December 1999.

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ACTION ON SMOKING AND HEALTH

LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE

[Volume II]

Memoranda and supplementary memoranda submitted by:

LIST OF APPENDICES TO THE MINUTES OF EVIDENCE

Memoranda submitted by:

LIST OF MEMORANDA REPORTED TO THE HOUSE BUT NOT PRINTED

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London, SW1 (tel 020 7219 3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays.

Memoranda or supplementary memoranda submitted by:

Department of Health [TB 1B, ID]

FOREST [TB 12A]

Imperial Tobacco Group Plc (Volumes 1 - 8) [TB 13E]

The British Thoracic Society [TB 14]

Action on Smoking and Health [TB 18A]

Mr Scott D Ballin [TB 21]

Tobacco Manufacturers' Association [TB 23A]

British American Tobacco [TB 28G]

RJ Reynolds Tobacco (UK) Limited [TB 31A Annex, 31C]

Mr David Pollock [TB 34]

Mr Bernie Ecclestone [TB 36C]

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SECOND REPORT

The Health Committee has agreed to the following Report:—

THE TOBACCO INDUSTRY AND THE HEALTH RISKS OF SMOKING

I INTRODUCTION

General

1. Although the first factory for their production opened in 1856, it was not until World War I that cigarettes accounted for over half of British tobacco sales. Cigarette consumption "increased rapidly" during the conflict, their "convenience in the trenches" and inclusion in soldiers' rations doing much to extend their popularity.[1] Even at that time, according to Mr Martin Broughton, Chairman of British American Tobacco, there was some knowledge of the health risks involved, as indicated by the use of the term "coffin nails" for cigarettes.[2] The First World War has, in the popular imagination, become associated with the wasteful loss of life on a huge scale. Indeed some 12% of all those recruited to fight for the allied forces who served on the western front lost their lives.[3] Ultimately, however, tobacco was to prove a far more prolific killer. It is now understood that tobacco kills 50% of those who use it over a lifetime and half of those before the age of 70.[4]

2. Almost any report on the health risks of smoking begins with a mass of statistics because the statistics in themselves point to the profound impact of tobacco on public health. Some 120,000 people are killed by tobacco each year in Britain alone, according to official figures.[5] The Royal College of Physicians describes cigarette smoking as "the single largest avoidable cause of premature death and disability in Britain" and "the greatest challenge and opportunity for all involved in improving the public health".[6] In the European Union, 15% of all deaths are attributed to smoking, that figure rising to 24% in respect of deaths in middle age (35-69 years).[7] The World Health Organization estimates that tobacco kills one in ten adults worldwide, costing at least four million lives in 1998. As the tobacco epidemic continues its progression from developed to less developed countries it estimates that this proportion will increase to one in six of all deaths, or ten million deaths each year by 2030. On present trends, of the children alive today in the world, 250 million will be killed by tobacco.[8]

3. In concluding his recent Green College Lecture, Sir Richard Doll, one of the pioneers in the field of epidemiology relating to tobacco use, remarked:

> "That so many diseases - major and minor- should be related to smoking is one of the most astonishing findings of medical research in this century; less astonishing perhaps than the fact that so many people have ignored it."[9]

In an appendix to his lecture, Sir Richard lists those diseases "caused in part by smoking":[10]

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1 Ev., pp.1, 13, 20; *Nicotine Addiction in Britain: A Report of the Tobacco Advisory Group of the Royal College of Physicians*, 2000, p.4.
2 Q446.
3 Denis Winter, *Death's Men: Soldiers of the Great War*,1978, p.193.
4 *Smoking Kills, a White Paper on Tobacco* (Cm 4177), 1998, p.7.
5 C. Callum, *The UK Smoking Epidemic: Deaths in 1995*, Health Education Authority, 1998, cited in *Smoking Kills*, p.3.
6 *Nicotine Addiction in Britain,* p.183.
7 COM (1999) 407 Final, p.6.
8 Ev., p.500.
9 Ev., p.26.
10 Ev., pp.33-34.

CANCERS CAUSED IN PART BY SMOKING

Cancer of:

Lip	Myeloid Leukaemia
Nose	Stomach
*Lung	Kidney Pelvis
*Larynx	Kidney Body
*Mouth	Bladder
*Pharynx	Pancreas
*Oesophagus	Liver

*Risk increased five or more times

VASCULAR DISEASES CAUSED IN PART BY SMOKING

Ischaemic heart disease	*Aortic Aneurysm
Myocardial degeneration	*Peripheral Vascular Disease
Hypertension (fatal)	*Buerger's Disease
Arteriosclerosis	*Pulmonary Heart Disease
Subarachnoid Haemorrhage	
Cerebral Thrombosis	
Cerebral Haemorrhage	

*Risk increased five or more times

RESPIRATORY DISEASES CAUSED IN PART BY SMOKING

*Chronic Obstructive Lung Disease

Pneumonia

Asthma

Pulmonary Tuberculosis

*Risk increased five or more times

OTHER DISEASES CAUSED IN PART BY SMOKING

Gastric Ulcer	Periodontitis
Duodenal Ulcer	*Tobacco Amblyopia
Crohn's Disease	Age related macular degeneration
Osteoporosis	Cataract
Reduced Fecundity	Reduced growth of foetus

*Risk increased five or more times

He also lists those few conditions in which smoking has apparent health benefits:

DISEASES INVERSELY ASSOCIATED WITH SMOKING

Parkinson's Disease	Cancer of body of uterus
Ulcerative Colitis	Fibroids
Aphthous Ulcers	Nausea and vomiting of pregnancy
Allergic Alveolitis	Pre-eclampsia
?Alzheimer's Disease[11]	

A more detailed analysis of the extent to which smoking contributes to death comes in the latest report from the Royal College of Physicians:[12]

Estimated number and percentage of deaths attributable to smoking by cause, UK 1997.

Deaths from disease estimated to be caused by smoking

	Number			As % of all deaths from disease		
Diseases caused in part by	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
Lung	19,600	9,600	29,200	89	75	84
Upper respiratory	1,500	400	1,900	74	50	66
Oesophagus	2,900	1,700	4,600	71	65	68
Bladder	1,600	300	1,900	47	19	37
Kidney	700	100	800	40	6	27
Stomach	1,600	300	1,900	35	11	26
Pancreas	600	900	1,500	20	26	23
Unspecified site	2,400	600	3,000	33	7	20
Myeloid leukaemia	200	100	300	19	11	15
Respiratory						
Chronic obstructive lung disease	14,000	9,700	23,700	86	81	84
Pneumonia	5,600	4,800	10,500	23	13	17
Circulatory						
Ischaemic heart disease	16,800	7,500	24,300	22	12	17
Cerebrovascular disease	3,000	3,800	6,900	12	9	10
Aortic aneurysm	3,800	2,000	5,800	61	52	57
Myocardial degeneration	200	300	500	22	12	15
Atherosclerosis	100	100	200	15	7	10
Digestive						
Ulcer of stomach or duodenum	900	1,000	2,000	45	45	45
Total caused by smoking	*75,600*	*43,200*	*118,800*			
Diseases prevented in part by smoking						
Parkinson's disease	900	400	1,300	55	28	43
Endometrial cancer	-	100	100	-	17	17
Total prevented by smoking	*900*	*500*	*1,400*			
Deaths from all causes due to smoking						
(Caused less prevented)	**74,700**	**42,700**	**117,400**			

Totals may not add up due to rounding to nearest 100.

[11] The evidence on the impact of smoking on Alzheimer's disease is unclear. See eg P N Lee, "Smoking and Alzheimer's Disease: A Review of the Epidemiological Evidence", *Neuroepidemiology* 1994:13(4), pp.131-44; A Ott, A J C Slooter *et al*, "Smoking and Risk of Dementia and Alzheimer's Disease in a Population-Based Cohort Study", *The Lancet* 1998:351, pp.1840-43; P A Newhouse and J R Hughes, "The Role of Nicotine and Nicotinic Mechanisms in Neuropsychiatric Disease", *British Journal of Addiction*, 1991:86(5), pp.521-26.

[12] *Nicotine Addiction in Britain*, p.17.

4. The pattern of smoking diseases varies considerably between, and sometimes even within, countries. Until recently most epidemiological studies concentrated on Western countries, but studies are now emerging from lower-income countries such as India and China. The recent World Bank report *Curbing the Epidemic* noted that deaths in China from ischaemic heart disease make up a far smaller proportion of deaths caused by tobacco than in the West; in China, respiratory diseases and cancers account for most deaths while for a "significant minority" the cause of death is tuberculosis.[13] Whilst lung cancer is an important hazard, a major study of the health effects of tobacco in China found "a tenfold variation from one Chinese city to another".[14] Nevertheless, despite these differences, the outcomes are much the same. As the World Bank concluded "it appears that the overall *proportion* who are eventually killed by persistent cigarette smoking is generally about one in two in many populations".[15]

5. The Health Committee has not examined directly the health risks of smoking in its previous inquiries. We have, however, issued two reports relating to the role of advertising in relation to cigarette consumption. In the previous Parliament we concluded "in the face of the evidence that has now been accumulated, the Government can no longer maintain its position that a further tightening of tobacco advertising controls is unlikely to contribute to a reduction of the prevalence of smoking in the UK".[16] Then in our First Report of the current Parliament we expressed our concern at the Government's proposal to seek an EC directive which contained an exemption for Formula One from the proposed advertising ban.[17]

6. During the course of this inquiry we have often drawn attention to the fact that it was as long ago as 1954 that a health minister, Iain Macleod, disclosed in a written Answer to the House of Commons that it was "established that there is a relationship between smoking and cancer of the lung".[18] The ambivalence of governments towards the consequences of moving from an acknowledgment of the dangers of smoking to taking action to curb it is well summed up in Iain Macleod's later recollection that he "earned the plaudits of the Treasury, a lot of news coverage, and a headache by chain-smoking my way through my press conference announcing the first 'conclusive' findings of the causal link".[19]

7. It seemed astonishing to us that, almost 50 years after Government recognized the dangers inherent in smoking, tobacco products remained on sale in a remarkably unregulated fashion. In July 1999 we announced our intention to conduct an inquiry into "The Tobacco Industry and the Health Risks of Smoking". Our terms of reference were as follows:

> "The Committee will examine what action the tobacco industry has taken, and is currently taking, in response to the scientific knowledge of the harmful effects of smoking and the addictive nature of nicotine. It will also assess the role of Government in providing consumer protection."[20]

8. Between November 1999 and February 2000 we took oral evidence from Department of Health (DoH) officials, the Chief Medical Officer (CMO), the Health Education Authority, Action on Smoking and Health (ASH),[21] Leigh, Day and Co. Solicitors, the World Health Organisation (WHO), the Royal College of Physicians (RCP), the British Medical Association (BMA), British American Tobacco (BAT), Gallaher Group Plc, Imperial Tobacco Group Plc, Philip Morris Europe S.A., R J Reynolds Tobacco (UK) Limited (RJR), Freedom Organisation for the Right to Smoke

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13 *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1999, p.25.
14 Richard Peto *et al*, "Tobacco - the Growing Epidemic", *Nature Medicine*, 5:1, pp.15-17.
15 *Curbing the Epidemic*, p.25.
16 *The European Commission's Proposed Directive on the Advertising of Tobacco Products*, Second Report of the Health Committee (HC221, Session 1992-93).
17 *Tobacco Advertising and the Proposed EC Directive*, First Report of the Health Committee (HC373, Session 1997-98).
18 *Official Report*, 12.2.54, cols. 173-74w.
19 Cited in Robert Shepherd, *Iain Macleod*, 1994, p.92.
20 Health Committee Press Notice 1998/99-19.
21 ASH describes its role as working "to explain, promote and defend policies and ideas that would help to reduce the burden of smoking related disease" (Q177). It is funded by: the Department of Health, the British Heart Foundation, the Cancer Research Campaign, the Imperial Cancer Research Fund, the European Commission, the WHO and individual donations (Q178).

(FOREST),[22] the Tobacco Manufacturers' Association (TMA), four advertising agencies (M&C Saatchi, CDP, Mustoe Merriman Herring & Levy, and TBWA GCT Simons Palmer Ltd), Mr Bernie Ecclestone, (Chairman, Formula One Management Limited), Mr Max Mosley (President, Fédération Internationale de l'Automobile (FIA)), the Rt Hon Kenneth Clarke MP (Deputy Chairman, BAT), the journalist Mr Duncan Campbell, Ms Yvette Cooper, MP, Parliamentary Under-Secretary of State, Minister for Public Health, and the Rt Hon Alan Milburn, MP, Secretary of State, Department of Health.

9. In the course of this inquiry we have also received over 100 written memoranda. We are grateful to all those who have submitted written and oral evidence.

10. In November-December 1999 we undertook a visit to the USA as part of our inquiry. Recent activity in the USA has radically altered the climate of discussion over the impact of tobacco on public health. In August 1994 the State of Minnesota and Blue Cross and Blue Shield of Minnesota filed a complaint against the tobacco industry in the USA. The resulting trial led to the release of over 30 million pages of internal documents from the tobacco companies. On 16 November 1998 a $206 billion (over 25 years) settlement between the principal US tobacco companies and 46 states that had sued to recoup the costs of treating people with smoking-related diseases was announced. Separate deals had already been agreed with Mississippi ($3.36 billion over 25 years), Florida ($11 billion over an indefinite period), Texas ($15.32 billion over 25 years) and Minnesota ($5.6 billion over 25 years).[23]

11. In order to obtain a fuller picture of developments in the USA we met The Food & Drug Administration (FDA), Clifford Douglas of Tobacco Control Law & Policy Consulting, Star Tobacco, the National Smokers Alliance, the National Cancer Policy Board, Smoke Free Maryland, members of the Maryland Senate, members of the Maryland House of Delegates, Dr Benjamin, Secretary of Health and Mental Hygiene in the state of Maryland, Donna Jacobs, Governor's Deputy Chief, Maryland, the Governor of Maryland, the Campaign for Tobacco Free Kids, Mr Michael Pertschuk of the Advocacy Institute, Philip Morris Associates, the Federal Trade Commission, the Centre for Disease Control and Prevention and the National Cancer Institute.

12. Since much of the regulation which applies to tobacco products emanates from Brussels we also visited the European Commission in Brussels for discussions with the Health Commissioner and officials. Within the UK we visited the Centre for Tobacco Control Research at the Centre for Social Marketing, University of Strathclyde, the Tyne and Wear Health Action Zone, BAT's Research and Development Facility at Southampton and the same company's document depository at Guildford. We are grateful to all those who facilitated these visits.

13. We should also like to record our gratitude to our Specialist Advisors, Professor Gerard Hastings of the Centre for Tobacco Control Research at the Centre for Social Marketing at the University of Strathclyde, Professor Martin Jarvis of the Health Behaviour Unit, Department of Epidemiology and Public Health, University College, London and Professor Sir Richard Peto of the Nuffield Department of Clinical Medicine at the University of Oxford. In an inquiry in which much of the evidence has been of a tendentious nature they have guided us most expertly and, in our view, with complete objectivity.

Smoking in Britain

14. In the UK cigarette smoking levels rose rapidly in the first half of the century. By the end of World War II 65% of adult men and 41% of adult women smoked cigarettes.[24] Since 1974, smoking prevalence has been measured as part of the General Household Survey (GHS). In 1974 the GHS recorded cigarette smoking levels of 51% of men and 41% of women.[25] The latest figures are for 1998 and they indicate that in the UK currently 28% of men and 26% of women smoke.[26]

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[22] FOREST describes its role as being to "defend the rights of adults who choose to smoke tobacco and oppose those who want to discriminate against smokers and prohibit smoking at work and other places" (Ev., p.265). It receives 96% of its funding from the tobacco industry, the rest from individual donations (Q629).

[23] www.ash.org.uk/papers

[24] Ev., p.1.

[25] *GHS 1998*, p.116.

[26] These figures suggest that the hypothesis of a recent upturn in smoking in women, postulated in the 1996 GHS, may have been "overly pessimistic" (*GHS 1998*, pp.116-17).

15. In Britain, the market is dominated by two companies, Gallaher and Imperial:

Great Britain manufactured cigarette brand shares % Source: General Household Survey 1996 By Company	
Gallaher	40.3%
Imperial	28.3%
Rothmans [*now owned by BAT*]	5.9%
Philip Morris	7.3%
RJ Reynolds	2.7%
Supermarket own-labels (Japan Tobacco supplies many of these)	8.%
Others	7.5%

The leading brands are as follows:

Benson & Hedges (Gallaher)	17.5%
Silk Cut (Gallaher)	10.6%
Lambert & Butler (Imperial)	9.3%
Embassy (Imperial)	9.3%
Berkeley (Gallaher)	9.2%
John Player (Imperial)	7.2%
Marlboro (Philip Morris)	5.5%
Rothmans (Rothmans) [*now owned by BAT*]	4.1%
Regal (Imperial)	2.1%
Mayfair (Gallaher)	1.6%
Raffles (Philip Morris)	1.8%
Dickens & Grant (RJR)	1.4%
Dorchester (RJR)	0.9%

Note: *Rothmans has since been acquired by British American Tobacco [BAT]; R J Reynolds [RJR] has been sold to Japan Tobacco, but some brands have been sold to Gallaher. Imperial's market share is now nearer that of Gallaher.*

16. Reductions in smoking rates have thus been substantial but they have not been evenly distributed amongst social classes with the result that smoking is a prime cause of health inequalities. The Royal College of Physicians report noted that, over the period in which the GHS has been conducted, smoking prevalence fell by more than 50% in the most advantaged sector of British society, but remained static amongst the least advantaged.[27] Most teenage quitting was from affluent households.[28] The latest GHS suggests that in 1998 in households in the manual group 35% of men and 31% of women smoked whereas in non-manual households the figures were 21% of men and 21% of women. Men who lived in the unskilled manual groups were nearly three times as likely to smoke as those who lived in professional households (44% compared to 15%).[29]

[27] *Nicotine Addiction in Britain*, p.9.
[28] Q136.
[29] *GHS 1998*, p.119.

17. The papers we obtained from advertising agencies handling tobacco accounts (see below paragraph 82) showed that the agencies and their clients specifically targeted less well-off consumers. A market research report prepared for Gallaher describes this target sector in unflattering terms:

"Cluster 1 - 'Slobs'

27 per cent of cigarette smokers aged 18-24 years are represented by this cluster with 71 per cent of them being C2DEs ... Describing members of this cluster as 'Slobs' may seem unkind, but this title is earned by their low concern with their appearance and the little effort they make to keep themselves informed."

"Slobs ... downmarket .. less likely to have gone to further education ... committed smokers ... show commitment or concern about little else eg health, diet, appearance, promotions."[30]

18. The present Government gave an early indication of its commitment to combat tobacco in its White Paper *Smoking Kills* published in December 1998. This set out what they described as "the most comprehensive Government-wide programme of action ever undertaken to protect children from the effects of tobacco and to help the 7 out of 10 adult smokers who say that they want to give up".[31] The White Paper promised over £100 million of new money to combat tobacco. Its key proposals included:

- Up to £60 million to fund the first national NHS smoking cessation programme with advice clinics and support for adults wanting to quit including one week's free nicotine replacement therapy (NRT) for those entitled to free prescriptions in Health Action Zones (HAZs)[32]
- A £50 million publicity campaign especially targeting young people, adults who want to quit and pregnant women
- A pledge to introduce secondary legislation to end tobacco advertising as soon as possible
- Measures to crack down on sales to children
- Guidance to health authorities on strategies to tackle smoking
- A charter with the hospitality industry to ensure that consumers are better able to eat and drink in smoke-free atmospheres
- Consultation on a new Health and Safety Commission approved Code of Practice on smoking in the workplace

We discuss many of these proposals and their implications in the course of this report.

19. *Smoking Kills* set out three targets for judging the success of the Government's anti-smoking strategy. These were as follows:

- to reduce smoking among children from 13% to 9% or less by the year 2010 with a fall to 11% by the year 2005.
- to reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010 with a fall to 26% by 2005.
- to reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010 with a fall to 18% by the year 2005.[33]

We very much welcome the Government's firm commitment to action to combat smoking in its White Paper *Smoking Kills*. We do not, however, regard the targets they have set as sufficiently challenging to justify the Department of Health's rhetoric that it is for the first time tackling smoking seriously. The target trends for adult smoking are no more than would be expected extrapolating from the general trends since the 1970s. We believe that the DoH should set much tougher targets and take such measures as are open to it to achieve those targets.

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30 Ev., p.564.
31 DoH Press Notice 1998/0583.
32 Some 26 Health Action Zones have so far been established in England covering over 13 million people. They aim to "tackle health inequalities and modernise services through local innovation" in "areas of deprivation and poor health" (www.haznet.org.uk/hazs).
33 *Smoking Kills*, pp.82-84.

Awareness of the health risks of smoking

Active Smoking

20. Evidence on the harmful effects of tobacco has been accumulating since the end of the eighteenth century, most notably in relation to cancer.[34] A prize winning treatise in Germany in 1795 took as its title "Carcinoma of the lip is most frequent when people indulge in tobacco pipes".[35] The first case-control study of lung cancer was conducted by F H Müller in Cologne in 1939 who concluded that tobacco was an important cause of lung cancer.[36] By 1947 the increase in lung cancer deaths had become so pronounced in the UK that the Medical Research Council held a conference to discuss the reasons for it. Austin Hill was asked to conduct a case-control study to test whether this trend was associated with the increased consumption of cigarettes.

21. The association of smoking with vascular disease occurred rather later. In 1908 L Buerger noted that a rare form of vascular disease (subsequently called Buerger's disease) seldom occurred in non-smokers. In 1931, F L Hoffman noted a statistical correlation between the increasing number of reports of coronary thrombosis and the increasing consumption of cigarettes.[37] In 1940, F A Willius and J Berkson examined the records of 1,000 patients with the disease at the Mayo Clinic in Rochester Minnesota and 1,000 other patients matched for sex and age and found an association of smoking with coronary thrombosis.[38]

22. What Sir Richard Doll describes as a "watershed" in the study of the epidemiology of smoking occurred in 1950 with the publication of a series of case control studies.[39] Two major papers were published, one by Richard Doll himself in conjunction with Austin Hill and the other in the USA by E L Wynder and E A Graham. These drew attention to the risk of lung cancer: the American study concluded that "excessive and prolonged use of tobacco, especially of cigarettes, seems to be an important factor in the induction of bronchogenic cancer"; the British study argued that "cigarette smoking is a factor, and an important factor, in the production of carcinoma of the lung".[40] In 1951 a long term study of the effects of smoking in British doctors commenced. A questionnaire on smoking habits was distributed to all doctors on the medical register and survivors have been contacted regularly since 1957. The 40 year study published in 1994 and conducted by Sir Richard Doll and Sir Richard Peto showed that 80% of non-smokers survived to age 70 and 33% to age 85, whereas only 50% of heavy smokers survived to age 70 and 8% to 85. This led the authors to conclude: "It now seems that about half of all regular cigarette smokers will eventually be killed by their habit".[41]

23. Between 1952 and 1960 a series of huge North American cohort studies were undertaken. These culminated in 1959 in the American Cancer Society Twenty Five State study which followed a million subjects over five years and showed that "smokers of cigarettes had a [lung cancer] death rate of 9.2 times the rate for those who had never smoked".[42]

24. The Royal College of Physicians Report *Smoking and Health* was published in 1962 to alert health professionals to the dangers of smoking. This report concluded that cigarette smoking is a cause of lung cancer and bronchitis and probably contributes to the development of coronary heart disease and other illnesses. In the USA, similar conclusions were drawn in the *First Surgeon General's Report* on smoking and health in 1964.[43]

Passive smoking

25. In 1983 the Independent Scientific Committee on Smoking and Health (ISCSH) referred to several reports relating to the health risks of environmental tobacco smoke (ETS). In particular they noted findings that children exposed to tobacco smoke from their parents had an increased risk of respiratory illness and that passive smoking exacerbated symptoms in adults already

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[34] Ev., p.21.
[35] Ev., p.21.
[36] Ev., p.21.
[37] Ev., p.22.
[38] Ev., p.22.
[39] Ev., p.23.
[40] Ev., p.23.
[41] Ev., p.2.
[42] Ev., p.2.
[43] Ev., p.2.

suffering from coronary and other arterial diseases.[44] The tentative connection between ETS and lung cancer was explored in more detail by the same committee in its Fourth Report in 1988. It concluded that there was "an increase in the risk of lung cancer from exposure to ETS in the range of 10-30 per cent" (that is, people who had been exposed to ETS for most of their lives had a 10% to 30% higher risk of lung cancer than non-smokers who were not exposed to tobacco smoke) and that each year several hundred smokers in the UK died from lung cancer contracted by passive smoking.[45] In 1992 the US Environmental Protection Agency published a report *Respiratory Health Effects of Passive Smoking: Lung Cancer and other Disorders* which "confirmed the findings published in the Fourth Report on the effects of ETS exposure in relation to lung cancer and to respiratory diseases in children," considered "the effect of ETS exposure on the development of ischaemic heart disease," and also "identified additional links between passive smoking and certain childhood illnesses".[46]

26. The First Report of the Scientific Committee on Tobacco and Health (SCOTH), published in March 1998, offered the most comprehensive analysis to date. It concluded that "exposure to ETS is a cause of lung cancer, and in those with long term exposure, the increased risk is in the order of 20-30%. Exposure to ETS is a cause of ischaemic heart diseases.... Smoking in the presence of infants and children is a cause of serious respiratory illness and asthmatic attacks. Sudden infant death syndrome.... is associated with exposure to ETS. The association is judged to be one of cause and effect".[47]

27. The recent report of the Confidential Enquiry into Stillbirths and Deaths in Infancy indicated that Sudden Infant Death Syndrome (SIDS) was substantially more prevalent in households where an infant was exposed to tobacco smoke. This study concluded that "the more hours the infant was exposed to smoke the greater the risk". Reviewing other literature on SIDS it suggested that "despite the absence of direct experimental evidence, the relationship between smoking and SIDS is probably causal". The report called for "public education about the risks of smoking in the home particularly in relation to respiratory diseases in children" and that health education programmes "should focus on the dangers of ETS in foetal development and particularly in the sudden infant death syndrome". The Committee recommended that "smoking in public places should be restricted on the grounds of public health", and suggested there was "a need for public education about the risks of smoking in the home....".[48]

Nicotine addiction

28. The Royal College of Physicians 1962 and 1971 reports on smoking recognized that smokers might be addicted to nicotine.[49] In Britain more specific research which traced the effects of nicotine was, according to the RCP, conducted at two locations. One was the Institute of Psychiatry, where the development of the blood nicotine assay "helped to establish the role of nicotine as the major controlling factor in smokers' regulation of smoke intake".[50] The second location where such research was being conducted was within the tobacco industry itself. According to the RCP the industry was "establishing a sophisticated understanding of the role of nicotine in smoking behaviour".[51]

29. It has taken some time for the implications of the role of nicotine addiction in smoking to be reflected in public health policies. The 1980s saw a number of studies analysing nicotine addictiveness using animal self-administration studies, as well as neurochemical studies, and analyses of absorption and dependence and craving and withdrawal. A major influence on the climate of policy was the publication in 1988 of the US Surgeon General's Report, *The health consequences of smoking, nicotine addiction*. The analysis that nicotine addiction underlay smoking behaviour led to the US Food and Drug Administration attempting in 1996 to assert jurisdiction over tobacco products.

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[44] Ev., p.3.
[45] Ev., p.3.
[46] *Report of the Scientific Committee on Tobacco and Health*, 1998, p.27.
[47] *Report of the Scientific Committee on Tobacco and Health*, 1998, p.33.
[48] *Sudden Unexpected Deaths in Infancy, The CESDI SUDI Studies 1993-1996*, Ed. P. Fleming, P. Blair, C. Bacon and J. Berry, 2000, p.90.
[49] *Nicotine Addiction in Britain*, 2000, p.90.
[50] *ibid.*, p.90.
[51] *ibid.*, p.91.

30. Normally the FDA regulated drugs which manufacturers wanted to put on the market, that is to say manufacturers themselves sought regulation. The cigarette companies, however, strenuously resisted regulation and mounted a legal challenge to the FDA. Provision existed in statute to allow the FDA to take into account the *intent* of the manufacturer (so that the FDA merely needed to prove that the cigarette companies intended to deliver a "pharmacologic effect" for it to claim jurisdiction over tobacco products).[52] The FDA felt that this evidence was not clear in 1994 so they mounted a lengthy investigation into the use of nicotine in tobacco products. Following this investigation the FDA concluded that cigarettes "were delivery devices for the drug nicotine".[53]

31. During their investigations the FDA learnt precisely how the US cigarette companies had blended tobacco products. One company's handbook on leaf blending was anonymously submitted and from that the agency "learned that tobacco companies used chemical additives to affect the delivery of nicotine".[54] The actual blending allowed the companies to achieve fine tuning over the levels of the nicotine delivered. The former director of applied research at Philip Morris told the agency that "product developers and blend and leaf specialists at Philip Morris were responsible for manipulating and controlling the design and production of cigarettes in order to satisfy the customer's need for nicotine".[55]

32. The Supreme Court rejected the FDA's case on 21 March 2000. It determined that the statute setting up the FDA, the Food Drugs and Cosmetic Act, excluded tobacco which Congress had sought to control by means of other measures.[56]

33. We believe that the publication of the recent RCP report *Nicotine Addiction in Britain* should have as much impact on the public health debate on smoking as the seminal studies relating to lung cancer and heart disease of the 1950s and early 1960s. The RCP reviewed an enormous amount of material. For example, they analysed whether nicotine use through smoking met standard diagnostic criteria for addiction, a point we pursued with the companies. They listed the two most widely recognized diagnostic criteria for substance dependence - the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders DSM-IV criteria and the World Health Organization International Classification of Diseases ICD-10 criteria:

Summary of Diagnostic and Statistical Manual of Mental Disorders, DSM-IV and International Classification of Diseases ICD-10 criteria for substance dependence.[57]

DSM-IV	ICD-10
At least 3 of:	A cluster of behavioural cognitive and physiological phenomena that develop after repeated substance use and that typically include:
Substance often taken in larger amounts or over a longer period than intended	A strong desire to take the drug
Persistent desire or unsuccessful efforts to cut down or control use	Difficulty controlling use
A great deal of time spent in activities necessary to obtain the substance, use the substance or recover from its effects	
Important social, occupational or recreational activities given up or reduced because of substance abuse	A higher priority given to drug use than to other activities and obligations

[52] David A Kessler *et al.*, "The Food and Drug Administration's Regulation of Tobacco Products", *The New England Journal of Medicine*, 1996:335, p.988.
[53] *ibid.*, p.991.
[54] *ibid.*, p.990.
[55] *ibid.*, p.990.
[56] *The Times*, 22.3.00. The text of the judgment can be found at www.cornell.edu/supct.
[57] *Nicotine Addiction in Britain*, p.85.

Continued substance use despite knowledge or having a persistent or recurrent social, psychological or physical problem that is caused or exacerbated by the use of the substance	Persisting in use despite harmful consequences
Tolerance: need for markedly increased amounts of the substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount	Increased tolerance
Withdrawal: the characteristic withdrawal syndrome or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	Sometimes, a physical withdrawal state

The RCP concluded that smoking particularly met the criteria for "difficulty in controlling use" "continued use despite harmful consequences" "tolerance" and "withdrawal".[58] Overall, **the RCP drew the following main conclusion:**

> **"Cigarette smoking should be understood as a manifestation of nicotine addiction ... the extent to which smokers are addicted to nicotine is comparable with addiction to 'hard' drugs such as heroin and cocaine."[59]**

We endorse this conclusion, which underlies many of the recommendations in our report and is, we believe, of fundamental importance to policy makers in the UK and elsewhere.

The response of the tobacco companies to evidence of the health risks of smoking

34. Evidence from internal company memoranda, many of which have come to light as a result of the Minnesota litigation, suggests that tobacco companies have been aware of the dangers of smoking for decades. Mr Martyn Day, a solicitor in the firm of Leigh, Day and Co., which represented hundreds of claimants in unsuccessful actions against the tobacco companies between 1992-98 and had access to "hundreds of thousands of pages"[60] of internal tobacco company documents under the discovery process, suggested "in 1958 Dr Bentley, a leading research scientist for Imperial, accompanied two other British tobacco experts on a trip to meet a number of scientists from the US tobacco industry and other independent experts. In their report of the meeting to Imperial they said: 'with one exception ... the individuals whom we met believed that smoking causes lung cancer'."[61] The joint memorandum from ASH and the RCN quoted a number of other examples:

- "the sum total of scientific evidence establishes beyond reasonable doubt that cigarette smoke is a causal factor in the rapidly increasing incidence of human epidermiod cancer of the lung....[this is] a view with which we concur" (Paul Kotin, a pathologist at the Tobacco Industry Research Committee, 1957).[62]

- "the results of the research would appear to us to remove the controversy regarding the causation of the majority of human lung cancer.... to sum up we are of the opinion that the Auerbach work proves beyond reasonable doubt the causation of lung cancer by smoke." (The Research Manager, Gallaher, 1970. In 1998, Gallaher stated that this memorandum was an initial reaction and that its views were later discounted.).[63]

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58 *Nicotine Addiction in Britain*, pp.86-87.
59 *Nicotine Addiction in Britain*, p.183.
60 Ev., p.80.
61 Ev., p.90.
62 Ev., p.61.
63 Ev., pp.61-62.

Reviewing the Minnesota evidence, the World Health Organization concluded that for decades tobacco companies, including those in the UK, have "denied or minimized the overwhelming scientific evidence of the dangerous effects of tobacco".[64]

35. Little of the evidence we received from the tobacco companies dwelt on the public statements they had made in the past as to the health risks of smoking. Mr Martyn Day's memorandum, however, listed a number of public pronouncements on this subject made by senior representatives of tobacco companies since the 1950s:

- "The Tobacco Manufacturers Standing Committee stated yesterday, after considering the statements by the Minister of Health and the Medical Research Council, that it had not been established with any certainty and to what extent there might be a causal connection between smoking and cancer of the lung." (*The Times, 28 June 1957*)[65]

- Dr Wakeham, Vice-President of Philip Morris said:

"You must be trying to get me to admit that smoking is harmful. Anything can be considered harmful. Apple sauce is harmful if you get too much of it.

Q I don't think many people are dying from apple sauce.

Dr Wakeham: They're not eating that much. I think that if the company as a whole believed cigarettes were really harmful, we would be out of business. We're a very moralistic company." (*"Death in the West", Thames TV, 1976)*[66]

- "letter by Richard Duncan from BAT subsidiary saying "The company does not believe that cigarette smoking is harmful to health." (*The Sunday Times, 3 May 1990).*[67]

36. We sought to establish as accurately as we could the position of the major companies operating in the UK on the dangers of active and passive smoking and on the degree and nature of nicotine's addictiveness as delivered via cigarettes. The companies' stance was generally to 'recognise' the evidence, without tending to comment on it. For example, "Gallaher recognises that starting... in the 1950s, the quantity and quality of the statistical evidence reporting the association between cigarette smoking and lung cancer have increased. For many years, Gallaher has proceeded on the assumption that cigarette smokers are more likely to contract lung cancer and other diseases such as chronic bronchitis, heart disease and other vascular diseases than non-smokers".[68] In oral evidence, Mr Peter Wilson, Executive Chairman of Gallaher, said "we understand and accept that there is a general agreement amongst most people today, particularly the medical and scientific community, that smoking can be dangerous and can cause a number of diseases. I am not going to begin to argue with that ...".[69] Similarly Philip Morris in its memorandum said that it " recognizes, for example, that epidemiological studies have concluded that the incidence of lung cancer among smokers is many times greater than among non-smokers".[70]

37. Following the oral evidence session we submitted a number of detailed written questions to the companies to establish for the record their current public position on the health risks of smoking and the addictiveness of nicotine. The responses of the companies are summarized in the table below:

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[64] Ev., p.97.
[65] Ev., p.89.
[66] Ev., p.90.
[67] Ev., p.90.
[68] Ev., p.170.
[69] Q391.
[70] Ev., p.228.

(a) Does smoking cause lung cancer - "cause" meaning that smoking is an activity that results in there being more lung cancer deaths than there would otherwise be - other things being equal?	
BAT	"Yes"
Gallaher	"the strength of the statistical evidence is sufficient to conclude that it is substantially more probable than not" and it is "likely that as a result of smoking there are more ... deaths than there would otherwise be"
Imperial	"Smoking may be a cause of lung cancer, cardiovascular disease and respiratory disease" and "Imperial does not know whether or not there would be fewer deaths from these diseases in the absence of cigarette smoking"
RJ Reynolds	"Yes, based on the interpretation of the evidence by the public health authorities. Other factors ... may also be required to develop these diseases"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(b) Do you agree that smoking causes lung cancer beyond all reasonable doubt?	
BAT	"In populations, yes"
Gallaher	"It is generally accepted that smoking is neither a necessary ... nor a sufficient ... cause of disease and that causal conclusions in this regard are a matter of judgement... As such, it would as yet be going too far to say that causation has been proved beyond *all* reasonable doubt"
Imperial	"We do not agree that smoking causes [these] ... diseases beyond all reasonable doubt"
RJ Reynolds	"No - nobody knows what causes these diseases beyond all reasonable doubt"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(c) Does smoking cause heart and circulation disease - "cause" meaning that smoking is an activity that results in there being more heart and circulation disease related deaths than there would otherwise be - other things being equal?	
BAT	"Yes"
Gallaher	"the statistical evidence shows that smoking is a risk factor for some heart and circulation diseases ... the statistical evidence relating to smoking and these diseases is sufficiently strong to conclude that smoking can and does cause or contribute to the incidence of these diseases and that it is clearly likely that, as a result of smoking there are more deaths from these diseases than there would otherwise be..."
Imperial	"Smoking may be a cause of lung cancer, cardiovascular disease and respiratory disease" and "Imperial does not know whether or not there would be fewer deaths from these diseases in the absence of cigarette smoking"
RJ Reynolds	"Yes, based on the interpretation of the evidence by the public health authorities. Other factors ... may also be required to develop these diseases"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(d) Do you agree that smoking causes heart and circulation disease beyond all reasonable doubt?	
BAT	"[Notwithstanding certain complexities] in populations, yes"
Gallaher	"It is generally accepted that smoking is neither a necessary ... nor a sufficient ... cause of disease and that causal conclusions in this regard are a matter of judgement ... As such, it would as yet be going too far to say that causation has been proved beyond *all* reasonable doubt"
Imperial	"We do not agree that smoking causes [these] ... diseases beyond all reasonable doubt"
RJ Reynolds	"No - nobody knows what causes these diseases beyond all reasonable doubt"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(e) Does smoking cause respiratory illnesses such as emphysema - "cause" meaning that smoking is an activity that results in there being more respiratory illness deaths than there would otherwise be - other things being equal?	
BAT	"Yes"
Gallaher	"the statistical evidence shows smoking to be a risk factor for respiratory diseases ... it is clearly likely that, as a result of smoking there are more respiratory illness-related deaths than there would otherwise be ..."
Imperial	"Smoking may be a cause of lung cancer, cardiovascular disease and respiratory disease" and "Imperial does not know whether or not there would be fewer deaths from these diseases in the absence of cigarette smoking"
RJ Reynolds	"Yes, based on the interpretation of the evidence by the public health authorities. Other factors ... may also be required to develop these diseases"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(f) Do you agree that smoking causes respiratory illnesses beyond all reasonable doubt?	
BAT	"In populations, yes"
Gallaher	"It is generally accepted that smoking is neither a necessary ... nor a sufficient ... cause of disease and that causal conclusions in this regard are a matter of judgement. ... As such, it would as yet be going too far to say that causation has been proved beyond all reasonable doubt"
Imperial	"We do not agree that smoking causes [these] ... diseases beyond all reasonable doubt"
RJ Reynolds	"No - nobody knows what causes these diseases beyond all reasonable doubt"
Philip Morris	"There is an overwhelming medical and scientific consensus that cigarette causes lung cancer, heart disease, emphysema and other serious diseases in smokers ... smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers"

(g) Does your company believe that nicotine is addictive by reference to each of these criteria: DSM-IV and ICD 10?	
BAT	"The question seems to misunderstand the purpose of DSM-IV and the manner by which criteria are set out in DSM-IV. This manual does not set out to define criteria for judging whether a particular substance is addictive (or more accurately capable of producing dependence). Rather it provides standardised diagnostic criteria to assist clinicians in determining whether a person has a particular disorder ... We think that it is reasonable that, under these criteria, some smokers would be classified as being dependent on nicotine"
Gallaher	"DSM-IV is not rigid in its definition of 'substance dependence' ... [it] cautions against categorical use of the term 'dependence' noting, for example, that 'the diagnosis of Substance Dependence requires obtaining a detailed history from the individual' ... the diagnostic criteria for substance dependence in DSM-IV ... may be applied to certain individuals to support a finding of nicotine dependence ... The specific diagnostic criteria ... are not meant to be used in a cook book fashion ... as such smoking may or may not be assessed as supporting a finding of nicotine dependence ... ICD-10 categorises the use of both caffeine and tobacco, amongst other substances, as capable of leading to unspecified mental and behavioural disorders ... as such smoking may or may not be assessed as supporting a finding of nicotine dependence..."
Imperial	"We agree that nicotine could be regarded as addictive by reference to DSM-IV and ICD 10 but this does not mean that smokers are unable to stop smoking if they choose to do so"
RJ Reynolds	"Yes- nicotine can be seen as 'addictive' if what is meant by this is that it is capable of creating some of the dependence and withdrawal symptoms that are described in DSM IV and ICD 10"
Philip Morris	"We believe that it is important that smokers and non-smokers ... hear a single consistent message on the issue of smoking and addiction and we will not engage in a debate over the message provided by the public health authorities on this issue ... we will not debate the application of the criteria ... to smoking. As we stated in our submission ...cigarette smoking is addictive as that term is most commonly used today."[71]

38. The responses to our questions accurately reflected the positions taken during the evidence session. Gallaher, Philip Morris, BAT and R J Reynolds all either directly acknowledged that smoking caused serious diseases, or acknowledged that there was a consensus amongst public health bodies that this was the case.[72] In stark contrast, Mr Gareth Davis of Imperial refused to accept directly any of the evidence, nor did he appear to think it was his role to evaluate this evidence. He told us: "I do not think that we can say that it [smoking] is safe or unsafe ... we do not know whether it is safe or unsafe".[73] He added that "we do not agree that smoking has been shown to be a cause [of certain diseases]".[74] We discuss below our response to Imperial's position.

39. In its memorandum Imperial told us that, together with the Tobacco Manufacturers Study Committee / Tobacco Research Council, it "consulted and took advice from leading scientists on the direction of research carried out and the interpretation of the results of the research".[75] A list of distinguished scientists was supplied: Sir Charles Dodds, President of the RCP Committee of Air Pollution, Sir Ronald Fisher, Professor of Genetics at Cambridge University, Sir John Richardson, President of the Royal Society of Medicine, Lord Todd, Professor of Organic Chemistry at Cambridge University, Professors Sir Alexander Haddow, R D Passey and E Boyland of the Chester Beatty Institute of Cancer Research at the Royal Cancer Hospital London, Professors Sir Ernest Kennaway and J W S Blacklock of St Bartholomew's Hospital, Dr C M Fletcher, co-author of the 1962 RCP report on Smoking and Health, and Dr J W Cook of the MRC Carcinogenic Substances Research Unit, University of Exeter.

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[71] Information in the tables is sourced from Ev., pp.340-41, 356-57, 358, 359, 360.
[72] See QQ388-435 and QQ462-69 *passim.*
[73] QQ397-98.
[74] Q418.
[75] Ev., p.207.

40. We asked Imperial to supply us with the written interchanges between the company and these scientists.[76] We felt that the implication of Imperial drawing our attention to the advice they received from eminent medical authorities was that this advice had governed their conduct in assessing the health risks of smoking. The resulting dossier they submitted was extremely unconvincing. In the case of several scientists there was either no correspondence at all (Sir Ronald Fisher; Lord Todd; Sir Ernest Kennaway; J W Blacklock) or nothing which touched on matters of substance ((Dr W Carruthers and Dr J W Cook). From Sir Charles Dodd there were a mere three pages covering the period 1952-72. The bulk of the material comprised exchanges between Charles Fletcher and Geoffrey Todd of the Tobacco Research Council and related to research the TRC was funding in Professor Fletcher's laboratory. There is nothing here to suggest that Imperial was seriously seeking his views and advice; instead the correspondence generally deals merely with the administration of grants for research. In many cases the evidence is incomplete with only one side of the correspondence surviving. There are occasional indications that, if more of the correspondence survived, more would be known of the companies' actual understanding of the health risks of smoking. For example, Charles Fletcher describes a discussion with Geoffrey Todd thus: "The evidence you told me about certainly suggests that nicotine is the basis of cigarette addiction". In 1964 E Boyland suggested "greater efforts should be made to detect ... nitrosamines in cigarette smoke". Yet only recently have processes to remove nitrosamines been developed. Overall, however, the package of materials supplied is patchy and fails to give documentary support to the idea that these scientists were a source of valued advice on matters relating to the company's stance on smoking and health. Some of the deficiencies may be attributable to the passage of time, but the general lack of material in which Imperial either seeks or receives advice suggests that this may never have been a high priority.

41. We also sought the views of the five companies on the health risks of environmental tobacco smoke. Mr Wilson of Gallaher rejected the findings of SCOTH that, amongst other things, ETS caused lung cancer and heart disease.[77] In written evidence BAT told us that they believed that "the claim that ETS presents a health hazard is not supported by the science".[78] They argued that most studies of ETS have not shown any statistically significant increase in risk. In respect of dangers to children they noted "a number of reports of statistically significant increased risk of respiratory disorders in pre-school children exposed to ETS".[79] Here they contended that the increased risks may be due to other factors statistically more common in households with smokers such as diet and housing conditions. They went on to suggest that the pattern of increased risk is "not consistently replicated" in children of school age indicating that any real effects are short-lived. They concluded "it is right that parents and other adults be particularly sensitive to the needs of young children, especially infants, for a clean, comfortable environment. It makes sense not to smoke around infants, especially in poorly ventilated environments and not to smoke around young children for long periods".[80]

42. We found BAT's analysis of the epidemiology of environmental tobacco smoke largely unpersuasive. If they believe that no increased risk arises from passive smoking it is unclear why they thought it "makes sense" not to smoke around children for long periods. The word they - and Mr Wilson of Gallaher and Simon Clark of FOREST - used to describe the effect of ETS on non-smokers was "annoying".[81] We asked Mr Wilson whether he would define an asthmatic attack, which the SCOTH report considered could be triggered by ETS, as merely "annoying".[82] He replied that he accepted that ETS was "annoying, can cause this kind of unpleasantness but not lung cancer, heart disease etc." **Bearing in mind that asthma causes 1,400 death per year,[83] we do not regard asthma attacks as merely unpleasant and believe that policy goals related to ETS must take account of the real health risks it poses.**

43. We also questioned Mr David Davies of Philip Morris about the activities of his company in respect of the debate on ETS. We specifically asked him to explain the function of Operation Whitecoat and to indicate the role of the late Professor Roger Perry of Imperial College in his capacity as an advisor to the Environment Committee on its 1991 inquiry into indoor air quality, which included a substantial section on environmental tobacco smoke. Mr David Davies told us

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[76] TB13F (*not published*).
[77] Q581.
[78] Ev., p.159.
[79] Ev., p.160.
[80] Ev., p.160.
[81] Ev., p.159; Q614.
[82] *Report of the Scientific Committee on Tobacco and Health*, 1998, pp.31-32.
[83] ONS Mortality Statistics 1998. Figures are for England and Wales.

that Operation Whitecoat was "the name given to activities in which we engaged in the late eighties and early nineties which were designed to solicit the support of those who shared our views in relation to environmental tobacco smoke and indoor air quality". Mr Davies revealed that Professor Perry was associated with the tobacco industry from the late 1980s and "subsequently became affiliated directly with Philip Morris". Mr Davies assured us that Professor Perry's affiliation with the industry and with Philip Morris was "very well known".[84]

44. We wrote to Mr David Davies requesting further evidence that Professor Perry's contract with Philip Morris had been notified to the Environment Committee. In response they submitted a newspaper cutting from 1988 which noted that Professor Perry had conducted research on indoor air quality funded initially by the Tobacco Advisory Council and later by Philip Morris and a New Scientist article which, based on documents released as a result of the Minnesota litigation, suggested that Philip Morris "secretly recruited influential people to help allay fears about the health risks from passive smoking". This article also cited the former Clerk to the Environment Committee as acknowledging that the Committee members "knew Perry had done research for the tobacco industry"; according to the article, the Clerk went on to add "he cannot recall Perry mentioning that he had any deeper relationship with Philip Morris".[85] We went back to the then Clerk of the Environment Committee who confirmed that, as far as he was aware, the Committee had known that Professor Perry had conducted research in the past for the tobacco industry but had not been told of his other contracts with Philip Morris, although he acknowledged that Professor Perry "may have mentioned the fact that he had a general retainer from Philip Morris to the then Chairman, Sir Hugh Rossi MP".[86]

45. The issue of ETS is crucially important for the tobacco companies. The central strand of their defence of their activities is that smoking is a matter of free and informed adult choice. If dangers are found to attach to other people's smoke, and if non-smokers such as young children in a smoker's house are unable to avoid that smoke, those non-smokers are not exercising free choice at all. The extent of nicotine's addictiveness is similarly crucial. Mr Martyn Day told us that, in law, "if you get an individual case ... there is a big debate about whether someone voluntarily accepts the risk that they are pursuing - it is a legal argument called *volente* - part of the legal case would be that you cannot voluntarily accept a risk if you are addicted to the substance you have been using".[87] Similarly, ASH/RCN noted: "To recognize publicly the evidence for pharmacological nicotine addiction would ... undermine the assertion that smokers choose to do so as a matter of 'free will'. Without the 'free will' argument, a key part of the industry's defences in product liability litigation would be destroyed".[88] They draw attention to the startling image of seven Chief Executive Officers of US tobacco companies each testifying on oath during the 1994 US Congressional Hearings before the sub-committee on Health and the Environment of the Committee on Energy and Commerce that, in their view, nicotine was not addictive.[89]

46. In evidence in July 1999 before the Irish Joint Committee on Health and Children, Mr Ian Birks, Head of Corporate Affairs at Gallaher, told members:

> "The confusion in the debate is when we get to the use of the word addiction because it is an emotive word. It is a word which tends to get used in many different ways. A couple of weeks ago I was driving to work and I heard on the radio that 10 million Americans are addicted to the internet. We know of people who are addicted to soap operas, tea, coffee, cream cakes, chips etc. The difficulty is that when the word is used broadly to describe all kinds of behavioural habits, then clearly smoking is a habit. It can be a strong habit for some people, but we reject the fact that people are addicted to smoking and cannot stop smoking because they can and do."[90]

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[84] Q1067.
[85] *New Scientist*, 16.5.98, p.4 (cited Ev., p.634).
[86] Ev., p.630.
[87] Q1198.
[88] Ev., p.62.
[89] Ev., p.62.
[90] The Houses of the Oireachtas Joint Committee on Health and Children, Minutes of Evidence relating to Smoking and Health, November 1999, p.35.

47. In written evidence Gallaher drew attention to the fact that, whereas the US Surgeon General's report of 1964 characterised smoking as "an habituation rather than an addiction", in 1988 he concluded that cigarettes and other forms of tobacco were addicting.[91] The conclusion that Gallaher came to was that "the meaning of addiction has been given such a wide interpretation in today's society that it can encompass almost any type of behaviour, including smoking".[92] Mr Broughton of BAT similarly referred to the two definitions produced by the US Surgeon General. He contended that efforts by manufacturers to alter the nicotine:tar ratio so that smokers got more nicotine with reduced tar had not satisfied their consumers.[93] Nicotine he described as having a "mild" pharmacological effect "on a par with caffeine".[94] In its written memorandum BAT argued that "people say they are addicted to particular foods, using the internet, taking exercise, watching certain television programmes, or even to working".[95]

48. We asked Mr Broughton to expand on why his company had included such comparisons. He told us that "What the memorandum is trying to do is to say that we can get bogged down in semantics. There is a real danger that the current popular definition of addiction can be used for all sorts of things and not differentiate sufficiently between them. It does cover things like the internet. I think it is quite wrong to cover that ...".[96] But in his opening remarks to us, Mr Broughton demonstrated exactly why precision is essential in discriminating between habits and pharmacological addiction: "Let us just accept for the sake of moving forward that the popular understanding today is that smoking is addictive. Nevertheless our customers are not fools nor helpless addicts ...".[97] In our view, Mr Broughton's statement here shows just how dangerous and misleading the semantic vagueness which he purportedly decries can be: having indicated his unhappiness with the vagueness of the term "addiction" he then glibly exploits it. His confident assertion that his customers are not "helpless addicts" only makes sense if the addictiveness of smoking "in the popular understanding," which he apparently accepts, *excludes* pharmacological dependence.

The TMA and the Harrogate Research facility

49. The memorandum from the Tobacco Manufacturers' Association outlines the research conducted by, or on behalf of, the industry.[98] It notes that in 1954, following the announcement by the Minister of Health referred to above,[99] the tobacco companies funded a research grant of £250,000 to the Medical Research Council (MRC) to enable further investigation into smoking and health issues. The companies did not control the projects selected by the MRC for funding. The Tobacco Manufacturers' Standing Committee (TMSC), established in 1956, had no control and attached "no strings" to the grantees of the MRC controlled money. In 1959 it decided to implement research which it could direct itself and opened a purpose-built laboratory in Harrogate in September 1962. The TMA's evidence states that "the programme was concerned to investigate which, if any, properties of tobacco products might be responsible for the reported health risks associated with smoking, and how the products might be modified to reduce such risks". The Tobacco Research Council (TRC) succeeded the TMSC in 1963 to reflect the fact that the TMSC had decided "to conduct its own smoking and health research programme".[100] The core activity of the TRC, conducted at Harrogate, was to "obtain as much information as possible about the chemical nature of smoke" by means of a mouse skin-painting programme to measure "biological activity" in mouse skin caused by cigarette smoke condensate.[101] By 1969 "the major part of the TRC's research effort at Harrogate was concerned with the search for compounds in cigarette smoke with potential biological activity by fractionating the whole smoke and cigarette smoke" [ie breaking it down into its constituent parts]. The research was abandoned in 1970; the published review of activities noted: "this work ... has been taken as far as it profitably can."[102]

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[91] Ev., p.184.
[92] Ev., p.184.
[93] Q550.
[94] Q573. In its written evidence BAT described the pharmacological effects of nicotine as "milder than ... coffee". See Ev., p.153.
[95] Ev., p.153.
[96] Q575.
[97] Q388.
[98] Ev., pp.269-72.
[99] Ev., p.269.
[100] Ev., p.270.
[101] Ev., p.271.
[102] Ev., p.271.

50. Some observers have been cynical about the industry's motives in conducting research: the BMA's memorandum states that "In public, the industry maintained that the primary aim of this research was to help resolve the 'controversy' surrounding tobacco and health. In private, however, the industry-sponsored research was directed with an eye to reducing the likelihood of future liability actions".[103] A question that we believe should be considered is why the companies abandoned their strategy of joint research aimed at reducing or eliminating carcinogens from tobacco smoke. BAT emphasised in its analysis that the purpose of Harrogate was not to establish whether tobacco condensate could produce cancer in animal test models, a fact already "amply reported" in the scientific literature, but to identify "the chemical constituents of tobacco smoke primarily responsible for the mouse skin tumorigenicity and to investigate cigarette design modifications which might reduce the specific tumorigenicity".[104] According to the published reports of the TRC the Harrogate scientists got as far as determining that the carcinogens could be concentrated into "a single fraction representing only 0.2% by weight of the condensate".[105]

51. The companies agree that the task was abandoned when it became obvious that cigarette smoke was too complex to analyse sufficiently precisely so as to be able to eliminate specific carcinogens. Gallaher commented that in 1957 cigarette smoke was identified as containing "some twenty constituents or groups of constituents"; as analytical techniques improved "more than three thousand five hundred constituents have been identified".[106] A slightly different emphasis on what occurred at Harrogate was taken by Mr Martyn Day who has enjoyed unique access to the companies' documents:

> "It is very clear that the industry originally in the fifties and sixties thought there was something that they could do. They thought that they could extract the carcinogen to make the tobacco harmless and they should be doing that ostensibly. But as time wore on and they looked at more and more possibilities, it became clear that that was not the case, that there was nothing, apart from getting a totally new substance, that could make smoking harmless. As was said by Imperial, all that happened with this research was that the health community used the material ... and they felt that this was simply being used against them."[107]

Mr Day suggested that, from his memory of internal documents, Imperial and Philip Morris "were very clear that they wanted this research organization closed down ... it was producing research that was always being leaked by their opponents".[108] He told us that by the mid 1970s the companies felt that "harmony" had been reached: the severe regulatory pressures that they had feared once the true hazards of smoking had become apparent had not materialized and the companies felt "they could live within the confines of any regulator's line".[109]

52. We wanted to pursue with the Tobacco Manufacturers' Association (TMA) the extent to which the TRC had in fact succeeded in identifying any carcinogens in tobacco smoke. Mr David Swan, Chief Executive of the TMA, however, was unable to help us "interpret the history".[110] In its memorandum the TMA pointed out that "No-one who was involved in the joint industry research programme is employed by the TMA. The TMA is therefore not able to offer any first-hand knowledge of the matters discussed".[111] Nevertheless, a substantial section of the memorandum is taken up by an account of the activity of the TRC, the TMA's predecessor body. **We find it inherently unsatisfactory that the trade association of the tobacco companies was unable to comment on the research activities of its predecessor body. It seems to us that this is symptomatic of a more general failure by the industry as a whole to take responsibility for the effect of its activities.**

53. **We also find extremely unconvincing the explanation that the Harrogate research stopped simply because analytical techniques improved to such an extent that researchers were able to analyse ever-smaller components.** In the 28 years that have passed since the laboratories have closed it would, in our view, have been perfectly possible for the tobacco

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[103] Ev., p.110.
[104] Ev., p.136.
[105] Ev., p.137.
[106] Ev., p.174.
[107] Q1215.
[108] Q1217.
[109] Q1215.
[110] Q666.
[111] Ev., p.268.

companies, with all the resources at their disposal, to analyse the carcinogens in tobacco smoke and develop technology to make their product safer. Much more plausible, to us, is the explanation that the companies realized that they would not, ultimately, face severe regulatory pressures and could afford to wind down health-related research.

Conclusions

54. In analysing the past and present record of the tobacco industry's response to the health risks of smoking we have observed a pattern. It seems to us that the companies have sought to undermine the scientific consensus until such time as that position appears ridiculous. So the companies now generally accept that smoking is dangerous (but put forward distracting arguments to suggest that epidemiology is not an exact science, so that the figures for those killed by tobacco may be exaggerated); are equivocal about nicotine's addictiveness; and are still attempting to undermine the argument that passive smoking is dangerous. The current exceptions to this - based on the evidence they gave us - are firstly Philip Morris who claim no longer to comment on these issues except to protect themselves in law and secondly Imperial who claim not to know whether smoking is dangerous or nicotine addictive.

55. There is some evidence that, as far as the public is concerned, what the companies actually say no longer matters. The Consumers' Association surveyed attitudes to smoking and found that "mistrust of tobacco companies is high". Some 56% of respondents agreed with the statement "I don't trust tobacco companies" whilst only 16% disagreed with it.[112] **Tobacco companies are commercial enterprises whose imperatives have nothing in common with the public health community. Their past records of denial and obfuscation militate against any claims they may make towards scientific objectivity. We find ourselves most strongly agreeing with the viewpoint expressed by Dr Axel Gietz, Vice President of R J Reynolds Tobacco (UK) Limited: "we are aware that we do produce and market a very controversial product ... what we do in terms of product development ... is much more important than anything we say".[113] We believe it is for public health authorities to measure the risks of smoking and to set appropriate regulatory parameters.**

II MEASURES AGAINST SMOKING

Introduction

56. Primary and secondary legislation governs the sale of tobacco products to children, prohibits the sale of oral snuff,[114] governs the warnings to be carried on packets, stipulates maximum tar yields, and regulates the dimensions of notices exhibited in retail premises. The Health and Safety at Work etc Act 1974 requires employers to ensure so far as is reasonably practicable the health, safety and welfare of their employees. Finally a combination of legislation and voluntary agreements have regulated the extent to which tobacco products can be advertised (see below paragraph 80).

57. Historically, the regulation of tobacco products has been largely by means of voluntary agreements. Gallaher's summary of the various voluntary agreements relating to tobacco products extends to four pages and lists seventeen such agreements covering additives, tobacco substitutes, marketing, labelling, tar yields, and sports sponsorship.[115]

58. In written evidence, Imperial gave us their view that "There is already substantial regulation controlling the production and marketing of cigarettes. There is no lack of control".[116] Citing regulation of tar and nicotine yields and additives, and "numerous voluntary agreements concerning ... promotion", Mr Wilson of Gallaher described the tobacco companies as being "subject to a very high degree of regulation in many aspects of ... commercial life".[117] Evidence from public health groups presented a very different view of the extent of regulation of tobacco products. In its recent report *Nicotine Addiction in Britain* the RCP suggested that tobacco products "have enjoyed an unprecedented degree of freedom from the safety regulations that apply

[112] Ev., p.509.
[113] Q400.
[114] The Oral Snuff (Safety) Regulations 1989.
[115] Ev., pp200-203.
[116] Ev., p.226.
[117] Q596.

to virtually all other food or drug products available in Britain".[118] The Faculty of Public Health Medicine described current regulatory frameworks as "wholly unsatisfactory":

> "There are no EU regulations that require tobacco companies to reduce or control the concentration of specific harmful chemicals in tobacco smoke, other than the single European Union directive governing the maximum tar yield per cigarette."[119]

Similarly, Mr Clive Bates, Director of ASH argued:

> "Tobacco products ... do not fall conveniently into any pre-existing regulatory framework such as for pharmaceuticals or food and drink ... We can see the way pharmaceuticals are regulated incredibly tightly. Every single claim, every single ingredient, has to be backed up by very substantial trials, evidence and justification presented to a sceptical and arduous regulator. Tobacco products have very complicated designs and very sophisticated engineering and they face none of those kinds of regulations ... They are difficult to regulate ... so you need to do something from scratch. Sadly, governments round the world have not stepped up to this challenge."[120]

Mr Paul Lincoln, a director of the now-disbanded Health Education Authority said that in his view voluntary agreements had not worked and had "been breached in many ways". It was for this reason that he favoured statutory regulation.[121]

59. Our view is that **the current regulation applying to tobacco products is entirely inadequate**. By an accident of history, the huge health risks of tobacco only became clear well after the practice of smoking had become culturally entrenched. Below we examine the adequacy of the regulation of additives (paragraph 147). We also examine the paradox whereby nicotine replacement products are subject to strict regulation whereas tobacco products are subject only to very limited regulation.

60. We suggested to DoH officials that it seemed curious that drugs were regulated by the Medicines Control Agency and that food stuffs now fell under the aegis of the Food Standards Agency (FSA), while tobacco appeared to be subject to no serious regulation. The Chief Medical Officer told us that he was not aware of any proposals to incorporate tobacco products into the work of the FSA when its jurisdiction was being determined.[122] Mr Tim Baxter, the Team Leader of the Tobacco Policy Unit, also pointed out to us that tobacco products are specifically *excluded* from the terms of the Consumer Protection Act 1997, although "provision existed for secondary regulations to control tobacco products".[123] Our reservations appear to be mirrored by the general public. The majority of those questioned by the Consumers' Association (67%) agreed with the statement that "the government should do more to discourage smoking".[124]

61. Sir Alexander Macara, former chair of the BMA council, told us that he felt that one reason that the Government was afraid of introducing regulatory reform was "a terror about being accused of being nannies or health fascists".[125] **We take the view that if the Government fails to take the sort of direct regulatory action we recommend below as a consequence of its anxiety not to be seen to be 'nannying', it would be failing in its responsibilities.**

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[118] Ev., p.186.
[119] Ev., p.641.
[120] QQ179-80.
[121] Q113.
[122] Q95.
[123] Q96.
[124] Ev., p.508.
[125] Q338.

Measures to prevent sales to children

62. The sale of tobacco to children was first controlled by the Children's Act of 1908, which made it illegal to sell cigarettes to children under 16 years of age. This has been updated a number of times, most recently in 1991 with the passing of the Children and Young Person (Protection from Tobacco) Act. Current legislation proscribes the selling of any tobacco product to persons under the age of 16, requires the provision of warning statements regarding under age sales on retail premises and provides for enforcement action by local authorities.[126]

63. Although these laws have prohibited sales to anyone under the age of 16, there is clear evidence that many youngsters have little difficulty in buying tobacco.[127] The General Household Survey reveals that "nearly two thirds of people who had smoked regularly started before they were 18, and well over a third started before they reached the age of 16".[128] The Secretary of State told us that he did not know "the average age that people start smoking in this country".[129] We asked if the Department had commissioned any recent research on why children start smoking and if they had weighted each factor to assess its importance. Again, the Secretary of State said that this had not been done, although he told us he thought it probably needed to be.[130] **We believe that the Department should urgently commission comprehensive research relating to the age at which children start smoking, the reasons they begin, continue and quit smoking, the relationship between pack size and consumption by children, and the sources from which children obtain cigarettes. We believe that the Tobacco Regulatory Authority we propose below at paragraph 189 would be the appropriate body to commission and analyse such research.**

64. Notwithstanding the need for more research, we do know that children are most likely to use independent retailers to obtain their supplies. The following table from the 1998 Office for National Statistics (ONS) Report *Smoking, Drinking and Drug Use among Young Teenagers* indicates the usual source for cigarette purchases and emphasizes the significance of small, independent retailers:

ONS Table 5.12

Current smokers *(Percentage from each source)*

Usual source of cigarettes*	11/12 years	13 years	14 years	15 years	All current smokers
Bought from newsagents/tobacconist/sweet shop	39	49	64	77	65
Bought from garage shop	16	22	31	46	35
Bought from supermarket	6	5	16	29	19
Bought from other type of shop	10	10	13	22	16
Bought from machine	16	19	23	29	24
Bought from friends/relatives	35	39	25	25	28
Bought from someone else	21	30	12	13	16
Given by friends	68	66	64	56	61
Given by brother/sister	15	23	15	15	16
Given by mother/father	3	8	7	10	8
Found or taken	7	14	6	4	7
Bases (=100%)	57	77	321	454	727

* Percentages total more than 100 because many pupils gave more than one answer.

[126] Ev., p.4.
[127] See J. Dunmore, *Protecting children from tobacco: Enforcement of Tobacco Sales Legislation 1992-93. A Report by Parents against Tobacco*; C Smith, "Smoking and Young People: Some Recent Developments in Wales", *Health Education Journal*, 50:1, pp.8-11.
[128] *GHS 1998*, p.121.
[129] Q1304.
[130] Q1303.

65. The most recent figures in England and Wales for the number of offenders cautioned, defendants prosecuted and convicted and average fine given for offences suggests that there is considerable scope for improvement in measures to prevent youth access to tobacco products:

Number of offenders cautioned, defendants prosecuted and convicted and average fine given for offences relating to the sale of tobacco to persons aged under 16,[131] *England and Wales, 1994–98*[132]

Year	*Total cautioned*	*Total prosecuted*	*Total convicted*	*Average fine (£)*
1994	13	108	83	228
1995	8	173	142	230
1996	1	140	119	226
1997	5	138	119	242
1998	-	173	135	225

66. Whilst our remit does not extend to Scotland we are obliged to note that the situation there is worse still. Legal obstacles (see below paragraph 73) have meant that *no* successful prosecutions have been brought since the passing of the 1991 Act.

67. These figures make depressing reading. According to the Secretary of State the maximum permissible fine for these offences is £2,500; the average fine levied is, however, currently less than a tenth of that figure. Even though illegal purchases must be taking place on thousands of occasions each day, there are fewer than three convictions per week.

68. The policy stance of the tobacco companies, in their evidence to us, was clear and unequivocal in its opposition to children smoking. They insisted that they regarded smoking as an activity only for informed adults, and that the extent of smoking amongst children represented a very serious problem which required urgent action. They also detailed the various measures they themselves, either individually as companies or through their trade bodies, had taken to combat child smoking.

69. The tobacco industry is strongly in favour of greater use of proof of age cards. Mr Wilson of Gallaher and Mr Broughton of BAT told us that their companies actively supported and endorsed proof of age schemes.[133] Imperial and Philip Morris pointed to the TMA's support for the photo-identity Citizen's Card, which acted as a proof of age.[134] In addition both Philip Morris and R J Reynolds suggested that it would be helpful if the minimum age for purchase of tobacco products was raised to 18 years of age.[135] Several of the companies drew attention to campaigns they had supported both financially and operationally to deter retailers from selling to children. These included the "No Excuses" scheme run in cooperation with the National Federation of Retail Newsagents which aimed to stop retailers selling to children.[136] (We discuss in the next section the implications of the companies' marketing strategies for sales to children.)

70. To stop accidental breaches, shopkeepers need help to identify under age customers. The Secretary of State told us that he thought that proof of age schemes needed to be examined carefully. He felt that the sheer multiplicity of proof of age schemes led to confusion and that it would be advantageous if the various schemes could be integrated and co-ordinated.[137] We agree. **We believe that a much more widespread use of proof of age cards would reduce the incidence of retailers unwittingly selling tobacco products to children. We think it would be helpful if the Government could approve those photo-identity proof of age cards it regards as reliable and useful. Such cards could then bear an appropriate marking to indicate that they belonged to a Government approved scheme.**

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[131] Offences under Section 7 of the Children and Young Persons Act 1993 as amended by Section 1 of the Children and Young Persons (Protection from Tobacco) Act 1991.
[132] *Official Report*, 20.03.00, col. 463w.
[133] Q1045
[134] Ev., p.222; Ev., p.237.
[135] Ev., p.228.
[136] See eg Ev., pp. 161, 190 and 222.
[137] QQ1316-17.

71. Deliberate breaches need to be treated extremely seriously. The fact that smoking is so much part of every day life, and that the vast majority of smokers start as children can make the problem seem less important. However, in reality tobacco is as addictive as heroin and cocaine, as we discuss below, and kills one in two of its lifelong users; selling it to children is as reprehensible as selling them illegal drugs, and strong measures are needed to stop it. These must comprise high detection and conviction rates, combined with meaningful penalties. **Detection of those illegally selling tobacco to youngsters is the job of trading standards officers, and we believe they need to be given clear instructions, definite targets and dedicated resources. They should also be made accountable for the success of their operations and ensuring shopkeeper compliance.**

72. The Secretary of State told us that some local authorities ignored their responsibilities to carry out regular enforcement procedures. One very effective measure that had been used by some authorities was to send children, operating according to strict guidelines and instructions, into retailers to see whether they would be sold cigarettes.[138] Yet only just over half the local authorities employ this measure. FOREST described the use of such methods as "agent provocateur activities ... ominously reminiscent of Orwell's 'Junior Anti-Sex League".[139] Their assessment strikes us as absurd. We would regard the use of trained and supervised children as essential if the retailers of tobacco to youngsters are to be flushed out. **We believe it is deplorable that so many local authorities have failed in their responsibilities to deter under age tobacco sales. Those not undertaking regular enforcement procedures should be named and shamed.**

73. In Scotland it is impossible to use this approach at all. Legal guidance from the Scottish Office prevents children being used in test purchase cases. The intention is to protect children from a potentially stressful experience; ironically, however, it means that offending retailers are effectively immune from prosecution, and that children are instead being exposed to a major public health hazard. **We regret the fact that the Scottish Office has not modified its guidance, and call on the Secretary of State to make appropriate representations to achieve a uniformity of approach towards tackling sales of tobacco products to children.**

74. **The policy failure on youth access to tobacco results from both inadvertent and deliberate law breaking. This was recognized in the White Paper, which promised to draw up an enforcement protocol with local authorities to tackle both issues. We welcome this - the terms of the Children and Young Persons (Protection from Tobacco) Act need to be greatly strengthened - but we feel that the protocol will need to be strongly worded, and backed by both adequate resources and severe penalties for non-compliance, if it is to have any effect. We also note that, despite "lengthy discussions" having taken place, no such protocol has yet been agreed. With this in mind, it is our view that Government cannot simply shift the blame for lack of enforcement on to local authorities, trading standards officers and magistrates. It is essential that the Government issues clear guidelines and quickly develops effective protocols to ensure more test purchases take place and more convictions are secured.**

75. During our visit to Tyne and Wear Health Action Zone we were told by a trading standards officer that magistrates were often reluctant to issue tough penalties to retailers selling cigarettes to children.[140] **We recommend that magistrates should be actively encouraged to pass deterrent sentences by means of guidance from central Government.** However, we also believe that conventional mechanisms to punish offending retailers have been wholly inadequate. Tobacco sales are an important source of income for a typical corner shop. Not only do they generate profit in their own right, they also increase sales of other items such as confectionary or newspapers which smokers tend to buy along with their cigarettes. Set against this pattern of purchasing, fines averaging around £250 - and falling rather than rising in the most recent year for which figures are available - will have little impact. So we believe that more radical change is needed.

76. **One possible way to enhance deterrence, would be to introduce a system of 'negative licensing'. Rather than requiring all retailers to be licensed, this would simply forbid sale by those who have infringed the law. We believe that this would act as a potentially powerful deterrent. It would also be appealingly appropriate in that the punishment would fit the crime – "shopkeepers who sell to children can't be trusted to retail tobacco responsibly, therefore should not be permitted to do it at all". Such a system would also, we believe, act as an incentive for retailers and those aged 16 and over to involve themselves in proof of age schemes. However, perhaps the most attractive feature of negative licensing is that it would**

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[138] The guidelines are set out in Home Office Circular 17/1992 and require, for example, the child to be accompanied by an officer at all times, to be trained, to tell the truth and not to work in areas where he/she is likely to be recognized.
[139] Ev., p.267.
[140] Q1313.

not require a new or extensive bureaucracy to support it. Existing local licensing boards could implement it as and when convictions occur. Alternatively, the Department might wish to assess the advantages of introducing a comprehensive licensing system for *all* retailers of tobacco, which would give consistency with the arrangements for the sale of alcohol.

77. **We believe that the measures set out in this and the previous section will bring about significant reductions in the numbers taking up smoking. The tobacco industry's public stance on children's smoking is explicit: they see tobacco use as an adult activity, do not endorse underage sales and, and in some cases support an increase of the legal age to 18. On the other hand, as noted above, most smokers start as children and complete prevention of child access to the product would have serious repercussions for their profits. The companies' response to the proposals made here will help establish where their priorities really lie.**

Measures to restrict marketing

78. The principle of controlling tobacco marketing was recognized as long ago as 1965, when the Government banned cigarette advertisements from television under the terms of the Television Act 1964.[141] Then in 1991, following prompting from a European Directive, the Broadcasting Act 1990 was used to remove advertisements for all tobacco products from television, cinema and radio. In 1998 a further European Directive was passed, calling for the removal of all tobacco advertising and sponsorship by 30 July 2006.[142] The White Paper *Smoking Kills* indicated the Government's commitment to end all tobacco advertising and sponsorship.

79. Advertising has also been controlled by an extensive set of voluntary regulations on the location and content of adverts, agreed between the DoH and the tobacco industry, and administered by an industry funded body, the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship (COMITAS) established in 1986, and comprising Government and industry members.

80. Cigarette advertising is governed by the cigarette code which was agreed between the DoH, manufacturers and importers of cigarettes (represented by the TMA and Imported Tobacco Products Authority Council) and the Advertising Standards Authority (ASA). The ASA is final arbiter of the rules. It deals with complaints about advertisement content and supervises the preclearance procedure for cigarette adverts operated by the Committee of Advertising Practice (CAP). The CAP rules are as follows:

[141] Ev., p.5.
[142] *Smoking Kills*, p.49.

- No advertisements should incite people to start smoking.
- Advertisements should not encourage smokers to increase their consumption or smoke to excess.
- Advertisements for coupon brands should not feature products unless these can be obtained through the redemption of coupons collected over a reasonable period of average consumption.
- Advertisements should never suggest that smoking is safe, healthy, natural, necessary for relaxation and concentration, popular or appropriate in all circumstances. Cigarettes should not be shown in the mouth and advertisements should not associate smoking with healthy eating or drinking.
- No more than half of those shown in groups should be smoking; smoking should not be shown in public places where it is usually not permitted.
- People can be shown smoking while engaged in work or leisure activities provided that the situation does not illustrate inappropriate smoking situations.
- Smoking should not be associated with social, sexual, romantic or business success and advertisements should not be sexually titillating, though the choice of a particular brand may be linked to taste and discernment. In particular, advertisements should not link smoking with people who are evidently wealthy, fashionable, sophisticated or successful or who possess other attributes or qualities that may reasonably be expected to command admiration or encourage emulation.
- Advertisements should not contain actual or implied testimonials or endorsements from well-known people, famous fictitious characters or people doing jobs or occupying positions which are generally regarded as admirable.
- No advertisement should play on the susceptibilities of those who are physically or emotionally vulnerable, particularly the young or immature. Advertisements should therefore avoid employing any approach which is more likely to attract the attention or sympathy of those under the age of 18.
- Anyone shown smoking should always be, and clearly be seen to be, over 25.
- No advertisement should exaggerate the pleasure of smoking or claim that it is daring or glamorous to smoke or that smoking enhances people's masculinity, femininity, appearance or independence.
- Advertisements that employ outdoor locations or those that depict people or animals should avoid any suggestion of a healthy or wholesome style of life. Any locations, people and objects depicted should not have undue aspirational, historical or cultural associations.
- Advertisements should not associate smoking with sport or with active or outdoor games.

81. Advertisements for sports sponsorship are covered by a separate voluntary agreement between the Department for Culture Media and Sport and the tobacco industry. The most recent agreement, concluded in 1995, stipulated, amongst other things, that:

- Of total expenditure on sports sponsorship by any company in any financial year not more than 15% may be spent on media advertising and promotional material directly related to the event excluding any advertisements or promotional material at the venue

- Press and poster advertisements should carry the Chief Medical Officer's health warnings

- Advertisements should not be displayed within 200 metres of the front entrance of schools

- Displays of sponsors signs and other aspects of publicity should be compatible with the cigarette code contained in the British Code of Advertising and Sales Promotion.[143]

82. As part of our inquiry, we obtained a substantial quantity of internal documents from five of the advertising agencies who have accounts with the UK tobacco industry. The advertising papers we obtained thoroughly discredit this voluntary approach: they show that commercial and competitive imperatives make the industry antithetical to its spirit, and provide numerous examples of concrete efforts to circumvent its letter. For example, in a memorandum from the agency CDP in April 1996 it is suggested: "Thought should also be given to style press specific concepts. Gallaher are keen to develop a B&H conversation with this target. Therefore scenarios and people (as young as we can push them with the ASA) to appeal to the 20-25 year olds should be considered".[144] Musto, Merriman, Herring & Levi, in a creative brief from 1998 noted that "CAP's rules and regulations considerably restrict what we can do in the UK ... But CAP rules don't apply outside the UK. There are some very good media opportunities targeting UK consumers abroad -

[143] *Fourth Agreement on Sponsorship of Sport by Tobacco Companies in the UK (1995).*
[144] Ev., p.554.

particularly aimed at holiday charter flight traffic. We want some executions using our characters that don't need to go through CAP's vigorous approval process and that can be tailored to British smokers abroad".[145] Similarly, CDP assessed the advantages of using British editions of newspapers such as the Sun or the News of the World produced in Spain as one of the ways round the proposed UK ban on tobacco advertising.[146]

83. The rules relating to sports sponsorship are also seen as susceptible to ingenious manipulation. In a creative brief written in 1997 CDP discussed some suggestions for the promotion of Benson and Hedges:

"As you will see we have a couple of thoughts:

(1) We feel if we can legally say the words 'A Special F1' [as in Special Filter] then we could utilise the area behind the driver's head - as you see - to attempt to get a little closer to more 'overtly' implying the brand on the car. Do you think we could get this past the various legal bodies? If Rothmans can get away with 'Racing' in the brand typeface, I think we may have a case!

(2) We wonder if you could slightly corrupt the Jordan logo to include a large 'ampersand' [from B&H]. I think that this would be sailing very close to the wind."[147]

84. Mr Chris Macleod, Chief Executive of CDP defended this proposal claiming that it had "the slight exuberance of an advertising agency".[148] He argued that it was reasonable for an advertising agency to take account of the parameters within which it had to work in drawing up its creative strategy. Our impression is that the purpose of the CAP rules in discouraging consumption and youth smoking has often been ignored by the advertising agencies who seem to pay attention solely to the letter rather than the spirit of the restrictions.

85. Elsewhere there are many papers which look at ways of mitigating the impact of a possible UK wide advertising ban. One brainstorming session at M&C Saatchi mooted the idea of attacking the then Health Minister, Tessa Jowell:

"undermine Jowell, position her as the Minister of Bans, undemocratic and rash/ hasty decisions. Undermine other supporters eg. Branson (cite connections with Rizla/Virgin.)"[149]

Mr Moray MacLennan, Joint Chief Executive of M&C Saatchi dismissed the document as one of a "list of ideas" none of which saw the light of day.[150] However, as the memorandum from the Centre for Tobacco Control Research at the University of Strathclyde (hereafter CTCR), which analysed these memoranda at our request noted, "a range of such ideas were taken into consumer research and one directly attacking Tessa Jowell was only dropped because it was felt to be ineffective".[151] Elsewhere in Saatchi brainstorming sessions, suggestions for getting round the ban ranged from advertising using billboards outside foreign embassies in the UK since these were not "UK territory", organizing competitions with lavish prizes, starting Pirate Radio stations and using Silk Cut to sponsor Elastoplast.[152] The fact that many of these suggestions are patently absurd and unworkable does not mean their appearance in the advertising papers is irrelevant. We accept that the advertising agencies, and their clients in the tobacco companies, have an obvious incentive to take whatever legal measures they can to achieve their commercial objectives. But in our view the many references in the papers to ways of getting round the advertising ban all serve to indicate a complete lack of any ethical perspective at the heart of the companies, and scant regard for the intent underlying the regulation.

86. In several instances we found advertising agencies actively striving to keep health issues *out* of the minds of smokers. For example, a proposal by CDP to feature bungee jumping in an advertisement for Hamlet cigars met with opposition from the client, Gallaher:

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[145] Ev., p.298.
[146] Ev., p.554.
[147] Ev., p.303.
[148] Q729.
[149] Ev., p.314.
[150] Q707.
[151] Ev., p.550.
[152] Ev., pp. 312-14.

> "The difficulty with Bungee Jumper from the client's point of view was that if the public followed through the logic of the execution, they would assume that a bungee jumper landing in concrete would most likely result in fatality. This as you can imagine is something of a taboo area with a tobacco manufacturer, and whilst they could therefore appreciate the fact that it could be considered a Hamlet Moment, its connotations were too grave if anyone had made the mental leap."[153]

Again, efforts were made to ensure that advertisements for Sovereign did not appear opposite the Health section of the Daily Mirror. Mr MacLennan of M&C Saatchi defended this as "entirely ethical" contending - in our view entirely illogically - "the only words on many advertisements say that smoking kills ... to put an image in there which encourages people to think of other aspects of health would be a strange way to advertise".[154]

87. Equally, on some occasions it appeared to suit the agencies to use health concerns to their, and their clients', advantage. Market research on Silk Cut packaging illustrated this with comments such as "white signals the low tar category" ... "low tar ('healthy') quality". One advertising debrief remarked that "the emotional territory of 'very low' [tar] is ownable as a higher-level benefit which cannot be usurped by rivals".[155] Another asked:

> "Who are we talking to? The core low tar (and Silk Cut) smoker is female ... upmarket, aged 25 plus, a smart health conscious professional who feels guilty about smoking but either doesn't want to give it up or can't. Although racked with guilt they feel reassured that in smoking low tar they are making a smart choice and will jump at any chance to make themselves feel better about their habit."

The triumphant conclusion followed: "low tar cigarettes can be associated with higher self-esteem".[156]

88. **The evidence we have reviewed from the advertising agencies leads us to conclude that, once more, voluntary agreements have served the industry well and the public badly. Regulations have been seen as hurdles to be overcome or side-stepped; legislation banning advertising as a challenge, a policy to be systematically undermined by whatever means possible. We recommend that any future regulation of marketing should be statutory, and overseen by an independent and powerful regulatory body which has the consumer's interest at heart, such as the Tobacco Regulatory Authority which we propose below at paragraph 189.**

89. **Most of the tobacco companies have sought to challenge the Government's commitment to introduce an advertising ban in advance of the date for implementation set by the EU directive. The argument they have repeatedly advanced is that tobacco advertising does not increase consumption, it merely persuades smokers to switch brands. However, looking through the documents that the agencies themselves produced, this view is completely discredited.**

90. The CTCR analysis pointed to material which it believed suggested that "specific campaigns are deliberately designed to support the idea of smoking, rather than individual brands".[157] They cited a document produced for Japan Tobacco which puts forward a campaign to promote the idea that "smoking can be a delight for everyone if it is done right".[158] Another report submitted by CDP on the cigar market emphasised "the need for the reinvigoration of the cigar market".[159] Lamenting the demise of "the tobacco culture" the strategy document - in flagrant violation of the CAP - urged the need to "step up our [Hamlet's] presence amongst younger and potential cigar smokers" or else risk losing "a whole generation of smokers, hastening the decline of the market and our brand".[160]

91. Furthermore, in both the cigar and cigarette markets the recruitment of "new entrants" is a key strategy. For example, Lambert & Butler and Marlboro are envied their success in this respect, but Silk Cut need to improve their performance. This was the conclusion reached in a Rothmans Consumer Research Department document from 1998:

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[153] Ev., p.303.
[154] Q716.
[155] Ev., p.565.
[156] Ev., p.565.
[157] Ev., p.548.
[158] Ev., p.548.
[159] Ev., p.549.
[160] Ev., p.549.

"The only economy brand to feature significantly in the list of new starter brands is L&B, which has improved its share of this group by over 2% (to 9.5%) since 1997 ... In 1996 Silk Cut KS was the biggest low tar brand among new entrants by a substantial margin. In 1996/7, the brand's share of new entrants has fallen to almost half its 1996 level - 6.0% from 11.2%. Qualitative research has repeatedly identified Silk Cut KS as dated and with an increasingly unappealing image."[161]

A Silk Cut planning meeting noted that "Ultra has yet to demonstrate a consistent ability to attract new smokers" and posed the question "can we expect the brand to appeal to new entrants - or is there a positioning that we can adopt that makes the brand more attractive to entrants?"[162] Given that most new recruits to smoking will in fact be children this preoccupation with attracting them is doubly concerning.

92. The issue of how the tobacco companies find replacement customers is crucial to our report. We have already drawn attention to the stated position of the tobacco companies that they totally oppose children smoking. The tobacco advertising papers on the whole are scrupulous in referring to "young adult" smokers although references are occasionally made to "the youth market" and more often to "young people".[163] We were startled to come across a piece of market research which did include 15 year olds amongst the sample consumers of Silk Cut smokers. The advertising agency concerned, M&C Saatchi, told us that the data involved came from Target Group Index and represented a standard industry resource which covers all products, not just tobacco. As Mr MacLennan explained:

"That is the main source for our industry, if there is a group of people which you want to target to find out what they do, what they think, how they behave ... There is no way of using that data without including 15-year-olds."[164]

Gallaher subsequently confirmed in written evidence that neither they nor their advertising agencies had any control over the methodology of the survey which was extremely widely used throughout industry.[165]

93. We have not found any explicit evidence to suggest that tobacco companies specifically and knowingly target children. What the papers make abundantly clear, however, is the primacy of the youth market for the tobacco companies and the importance of emotional messages and imagery. As the Centre for Tobacco Control Research noted: "the documents make it clear time and again that people, especially young people, smoke for emotional reasons, and that branding is being used to cater for these needs".[166] This confirms independent research which reveals a clear preference among child smokers for premium and heavily advertised brands.[167] A large proportion of the evidence deals with this market. Yet, as we have noted above, all research shows that only a small percentage of smokers start their smoking career after the age of 18.

94. The evidence we analysed led us to conclude that much of the very considerable ingenuity that went into the marketing of tobacco products to "young adults" would also hold appeal for those aged under 16. Whilst the tobacco companies ostensibly deplore the young aping their elders in choosing to smoke, the advertising agencies evince a mature understanding of the way in which this market works. A memorandum from Karen Rickards to Christine Barrass of Gallaher well demonstrates this:

"To smoke Marlboro Lights represents having passed a rite of passage, ie it is not something done by immature smokers. Neither is it smoked by older people, unlike Silk Cut which is seen as being fit for all. Silk Cut's universality of appeal is a problem for younger smokers for it means the brand lacks sufficient 'street cred.'"[168]

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[161] Ev., p.550.
[162] Ev., p.550.
[163] Ev., p.554.
[164] Q748.
[165] Ev., p.586.
[166] Ev., p.548.
[167] See R W Pollay *et al*, "The Last Straw? Cigarette Advertising and Realised Market Shares among Youths and Adults 1979-1993", *Journal of Marketing*, 1996:60, pp.1-16; J J Arnett and G Terhanian, "Adolescents' responses to cigarette advertisements: links between exposure, liking and the appeal of smoking", *Tobacco Control*, 1998:7(2), pp. 129-33.
[168] Ev., p.555.

95. A Mustoe Merriman Herring & Levy memorandum (in response to the proposed advertising ban) notes that, for "new smokers ... smoking ... is still a badge. A sign of maturity, discernment and independence".[169] A CDP presentation for Gallaher explained that the goal of the Benson and Hedges SF [Special Filter] advertising campaign was to "cement the brand into the repertoire of the experimental smoker".[170] TBWA concluded that the success of Marlboro Lights derived from its being "the aspirational lifestyle brand ... the Diet Coke of cigarettes".[171] A creative brief for Rothmans asked: "How do we want to change what people think, feel or know? We want to engage their aspirations and fantasies - 'I'd like to be there, do that, own that".[172] Another advertising executive bemoaned the fact that the "imagery" surrounding Silk Cut remained "unaspirational for the style conscious ... user imagery has become the very young (starter cigarette) and middle aged (part time, health freak, not a real smoker)".[173]

96. Campaigns aimed to provide what the CTCR described as "appropriate psychological support" to the young smoker. CDP in one brief described the client (Gallaher for Benson and Hedges) as being "adamant that she wants the shot to mirror the original, primarily because it researched so well against the younger style press target". The aim of a 1998 CDP/Gallaher campaign was to "boost B&H's image with style conscious 18-24s".[174] An exuberant - and to our minds utterly callous and offensive - creative brief for CDP epitomises the absence of any ethical dimension in the quest to promote a brand of cigarettes:

> "What do we want this work to achieve? We want more 18-34 year old blokes smoking B&H than ever before. We want to see these dudes ripping-up packets of Marlboro and Camel and treating them with the disdain that second rate, American filth deserves. For Christ's sake what the hell are people doing smoking brands that are made to be smoked by 'cowhands' and not by the youth of the trendiest, coolest, most happening country in the world. In many ways this brief is really a charity brief. Trying to help people recognise the error of their ways, thinking they are being cool smoking what Roy bloody Rogers smoked and opening their eyes to the unchallengeable truth that the coolest smoke in the world is a B&H.
>
> We want to see Great, British B&H in the Ben Sherman shirt pockets of Brit-popped, dance-crazed, Tequila drinking, Nike kicking, Fast Show watching, Loaded reading, Babe pulling, young gentlemen.
>
> So what we need is the coolest, most exciting, white knuckle ride of a campaign ever."[175]

97. We pressed Mr Paul Bainsfair, Chairman of TBWA GCT Simons Palmer Ltd. on how his company simultaneously sought to engage the "aspirations and fantasies" of 18-24 year olds and to avoid engaging those of 15 year olds. He told us that creative teams were not asked to work to a specific age but that the age bands indicated the "direction" of those people they felt would be interested in their advertising. He felt it was significant that the age band was as broad as it was and he noted "there is a huge difference between the 24-year-old and the 15-year-old". He suggested that the CAP rules prevented them from producing material which might appeal to children and that it was "unlikely that the kind of advertising we come up with would particularly appeal to a 15-year-old".[176]

98. We found Mr Bainsfair's argument inconsistent. He seemed to imply that the appeal of the marketing could stretch upwards, to engage the aspirations of the 24 year old, but not downwards to entice 15 year olds. We wondered why the subject matter mentioned in the briefs - and forming the subject matter of the style magazines to which the advertisements were directed - comprising as it did of "rock, cult, bikes, cars" would appeal to 18-year-olds but not to 15-year-olds. Mr Bainsfair was unable to offer any reasons why it should not and in the end conceded that "it is common sense that there is going to be an overlap. Some 15-year-olds are going to be more sophisticated than others".[177]

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[169] Ev., p.555.
[170] Ev., p.555.
[171] Ev., p.555.
[172] Ev., p.295.
[173] Ev., p.555.
[174] Ev., p.556.
[175] Ev., p.548.
[176] Q737.
[177] Q743.

99. **Our review of the copious evidence from the advertising agencies, which includes substantial quantities of market research, leads us to conclude that the advertising agencies have connived in promoting tobacco consumption, have shamelessly exploited smoking as an aspirational pursuit in ways which inevitably make it attractive to children, and have attempted to use their creative talents to undermine Government policy and evade regulation. We welcome the Government's commitment to end all forms of tobacco advertising and sponsorship.**

Formula One and sponsorship

100.The advertising papers indicated to us that sponsorship is used by the industry because of its tremendous potential to associate aspirational images with smoking. Formula One motor racing is the most blatant example of this so we paid particular attention to this area. For example, research conducted for Gallaher identified "More active sports, with potential to create a more dynamic, exciting brand image", which include: "Formula One, Big boat sailing, Basket ball, Ice Hockey". The image of Formula One is then described in more detail as "international, glamorous, challenging, fast, furious, dangerous, living life to the full and living life on the edge". The research concluded that Formula One can make the B&H brand more "dynamic", "macho" and "youthful".[178] This once more flagrantly disregards the spirit of the voluntary agreement. A further market research report concluded, in similar vein, that Formula One sponsorship "makes the brand very powerful" and lends associations with "young, fast, racy, adult, exciting, aspirational, but attainable environments".[179]

101. Mr Max Mosley, the President of Formula One's governing body, the FIA, told us that the percentage of sponsorship of Formula One teams made up by tobacco firms was diminishing. Nevertheless he admitted that the teams received "more money ... from the tobacco industry than we could if we had to get the same sponsorship money on the open market". In his view this was because "the tobacco people really have nowhere else to go".[180] Mr Mosley estimated that tobacco sponsorship of Formula One probably amounted to £200-300 million per annum.[181] In return for this expenditure, the tobacco companies obtained access to an annual television audience of 40 billion, "the largest television audience in sport".[182]

102. The advertising papers we examined indicated that advertising companies did not really distinguish between advertising and sponsorship. An internal CDP memorandum exulted in the apparent value for money to Gallaher of sponsoring the Jordan racing team:

> "As I'm sure you were aware there was excellent coverage of the new Jordan car last night on both the Nine o'clock News and the News at Ten ... If we assume that the coverage equated to a 60" commercial on each station, I've estimated the equivalent advertising value to be £185,000. When the value of additional news slots on Channel 4, Channel 5 and Sky are added in, I expect the figure would exceed £250,000. Not bad to start off with!"[183]

Another document prepared for Benson & Hedges described the "natural fit" between Formula One and "cigarette sponsorship" since Formula One was "international" "glamorous" and involved "rich people".[184] **In our view, such connotations blatantly subvert the attempts of successive Governments to dissociate smoking from aspiration and glamour. They also expose as pusillanimous the decision of the present Government to agree to the exemption for Formula One from the EU Directive banning advertising and sponsorship until 2006.**

103. Mr Mosley argued that if the EU had banned tobacco sponsorship of Formula One earlier than the proposed date of 2006, the teams would have sought to hold more races outside the EU, tobacco sponsorship of the teams would have remained in place, and the cars would still have been broadcast to the same European audience. This argument closely follows the Government's own defence of its position in its reply to our First Report of the present Parliament.[185]

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[178] Ev., p.560.
[179] Ev., p.562.
[180] Q822.
[181] Q830.
[182] www.fia.com [1999].
[183] Ev., p.563.
[184] Ev., pp.561-62.
[185] See Government Response to the First Report of the Health Committee, *Tobacco Advertising and the Proposed EC Directive,* Cm3859, 1998, para 3.

104. The FIA has, however, recently itself examined the need to eliminate tobacco advertising and sponsorship from Formula One in advance of the timetable set out by Europe. In March 1998 Mr Mosley announced that "since discussions on the proposed European Commission Directive on tobacco advertising began last year, the FIA has consistently said that if, presented with evidence of a direct link between tobacco advertising/ sponsorship and smoking, it would act to eliminate tobacco advertising and sponsorship from Formula One". It was further suggested that the FIA could bring in a world-wide ban as early as 2002.[186]

105. Even at the time of that announcement, Mr Mosley expressed his opinion that it was "inherently unlikely" that Formula One helped recruit smokers, a statement which we feel casts doubts on the objectivity with which the FIA can be expected to assess the evidence it receives.[187] Nevertheless, in a communiqué of 11 December 1998 the FIA World Motor Sport Council issued a call for evidence on the subject of whether, as a result of tobacco brand name sponsorship, a significant number of individuals who would not otherwise have made the decision to smoke became smokers.[188] Mr Mosley told us that the FIA had written to the Minister of Health in each of the 14 countries in which Grand Prix were held, along with other public health organizations, requesting evidence by 1 July 1999. The response was unimpressive: of the governments, only the UK, German, Argentine and Canadian governments actually replied. So the FIA "quietly forgot" their deadline and were still attempting to obtain answers from the other ten governments.[189] Mr Mosley also drew attention to the apparent logical inconsistency of the EU opposing the advertising of tobacco products whilst simultaneously providing 998 million ecus of subsidy to European tobacco growers under the CAP.[190]

106. **We share Mr Mosley's view that the EU's tobacco subsidy undermines its anti-tobacco health promotion strategy, a point we touch on elsewhere. We also regard it as unacceptable that the majority of health ministers questioned have not had the courtesy to reply to an invitation to contribute on a crucial health issue put to them by a major sporting body. We recommend that the Department of Health writes to each its counterparts in those countries which have and have not replied, to ascertain the nature of the replies given and the factors underlying the failure to reply by 10 governments. We would like to be provided with copies of this correspondence.**

107. Overall we conclude that sponsorship is working exactly like advertising. The only significant difference between the two that the papers acknowledge, is a disturbing one: the sales pitch in sponsorship is more hidden, enabling covert or "subliminal" messages that can get round the defences of their "wary" and media literate young targets. The following extracts from a market research report prepared for Gallaher relating to plans to sponsor night club parties and a related brief for the same clients from M&C Saatchi make this quite clear:

> "At each event the level of Silk Cut branding is intended to be subliminal, with no direct reference to Silk Cut cigarettes. However, a strong visual clue is given to the sponsor's identity by the night clubs (in which the events are staged) being 'clothed' in large areas of purple silk."

> "Urban Venturers: Aged between 18-30, students/graduates just out of university, short of money but spend all they have on good nights out. They are very advertising literate, and consequently very wary of big brands latching on to aspects of their lifestyle and exploiting them. To this end Silk Cut needs to complement the Renaissance imagery in an intriguing and stylish way."[191]

108. **We see no reason why sponsorship has been treated more leniently than advertising in the White Paper, and we call on the Government to remove tobacco sponsorship in general, and that pertaining to Formula One in particular, as soon as is legally possible. If more evidence is needed to support this move, Formula One Management's offer, in response to an inquiry we made, to fund independent research should be accepted and supervised by the Tobacco Regulatory Authority which we propose below.**[192]

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[186] www.fia.com
[187] www.fia.com
[188] www.fia.com
[189] Q857.
[190] QQ822, 857.
[191] Ev., p.563.
[192] Q857.

109. One of the reasons Formula One "fits" tobacco sponsorship so well is the way in which the cars themselves can, through their colouring and design, mirror the cigarette packet design itself. Indeed, the same word, "livery", is used to describe both. The potential benefits of this connection to advertisers was exemplified by a recent dispute between the FIA and BAT over the BAT sponsored British American Racing Team. The BAR team had sought to race one car with Lucky Strike branding and another with a different BAT brand, State Express 555. The FIA introduced a rule to stop this happening but this was challenged by BAT. The case went to arbitration, at considerable cost to the FIA, and the FIA in the end won.[193]

110. The advertising papers also confirmed that the pack was a powerful communication tool, and this has remained largely untouched by regulation. The CTCR in their memorandum described the pack as "the most important additional form of marketing communication".[194] A creative brief for Benson & Hedges remarked:

> "Remember this campaign has its origins in a very simple truth, the smokers of B&H when they put their pack on the pub table, will always have it noticed by their friends. It is their badge and all we are trying to do is celebrate it."[195]

A discussion document relating to "qualitative research" for the Sovereign brand noted that:

> "Cigarette packs are still considered to be badges, albeit that the cigarettes themselves seem to be losing a large amount of the glamour and aspiration that used to be associated with them."[196]

Sophisticated pack design has the power to reach vulnerable groups such as children, and circumvent the White Paper. The CTCR cited many examples from advertising documents drawing attention to the creative possibilities of the pack. One market research document recorded "reactions to alternative label designs":

> "Coloured labels tend to be seen as younger, for kids, like sweetie labels, cheap; comparisons made with alcopop brands (Hooch)
> Rolit like a pack of condoms or a "lite" chocolate/Options drink
> Rolit branding looked young - like sweets, Love Hearts, Refreshers."[197]

With the advertising ban apparently imminent the advertisers applied their ingenuity to other ways of marketing their products. A Mustoe, Merriman, Herring & Levi creative brief for Imperial's Lambert and Butler brand suggested that the company could: "Utilise modern printing techniques to the full by coming up with ways to use the pack outer as an advertising medium for Lambert and Butler. Make the L& B pack really stand out at point of sale against the competition."[198]

111. The advertising papers to which we have had unique access give a clear insight into the mentality both of the tobacco companies and the advertising agencies. They show how advertising - which will in due course be banned - forms only one part of the overall marketing strategy. In a post-ban environment, the other elements of the marketing strategy will assume greater significance but will also require greater regulation. The papers reveal just how important the packaging is to the companies, and how the point of sale displays will become a dominant means of communication. The packs have also been instrumental in the synergy between cigarette advertising and Formula One, as the cars have mimicked the packs in terms of colours and logos. These marketing efforts are focused on building evocative and powerful brands which have a particular appeal to the young smoker and potential recruits.

112. **We believe that the extraordinarily dangerous nature of the product being marketed means that tobacco companies cannot expect to operate in the same commercial environment as most other industries. We are concerned that tobacco manufacturers continue to think of cigarette packs as being a way either of exploiting the aspirational nature of their products or conveying implied health messages. Notwithstanding the potential restrictions caused by EU single market legislation we believe that the advantages and disadvantages of introducing generic or plain packaging for all tobacco products should be carefully assessed by the Tobacco**

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[193] Q867.
[194] Ev., p.559.
[195] Ev., p.559.
[196] Ev., p.559.
[197] Ev., p.559.
[198] Ev., p.559.

Regulatory Authority we propose below (paragraph 189). Such packaging would be of a standard colour with the brand name in a standard type face. Beyond this, the only other permitted information would be health warnings and consumer information about product contents.

113. **Other promotional techniques, such as direct marketing, point of sale displays, brand stretching (the branding of non-tobacco products such as clothing with tobacco marques) have also received less attention than advertising. We believe that the proposed Tobacco Regulatory Authority should monitor these activities, check compliance with current controls and propose new ones whenever there is a danger that a particular activity will encourage consumption. Innovative promotional efforts are also a threat, especially on the internet, and will, we believe, require careful monitoring.**

114. **Most fundamental of all, every effort needs to be made by both the Government and the tobacco companies to limit the appeal of tobacco brands to young and new smokers. As a start, we believe the Government should compile and publish information on those brands that have particular appeal amongst children. Such data could inform the operation of the proposed Tobacco Regulatory Authority, both in terms of its analysis of any ongoing marketing activity and its assessment of additives.**

Measures against environmental tobacco smoke

115. The Health and Safety at Work etc Act 1974 is the only legislation which acts to restrict the impact of environmental tobacco smoke. It requires employers to ensure, "so far as it is reasonably practicable", the health, safety and welfare of their employees.[199] In 1988 the Health and Safety Executive issued guidelines, most recently reviewed in 1992, telling employers what they should do to comply with health, safety and welfare law as regards passive smoking.[200]

116. The Government's White Paper, *Smoking Kills*, states that it does "not think a universal ban on smoking in all public places is justified while we can make fast and substantial progress in partnership with industry."[201] Instead, the Government has agreed a Charter with bodies representing the hospitality trade, requiring the signatories to the Charter to recognise "that there should be increasing facilities for non-smokers and the availability of clean air".[202] Independent research funded by the industry will monitor progress against targets. The White Paper states that "Consumers can do a lot by simply asking for smoke-free areas to be provided as well as by voting with their feet".[203]

117. The White Paper also states that the Government is "not going to ban smoking at work. But the Health and Safety Commission is going to consult on a new Approved Code of Practice on smoking in the workplace. This will considerably toughen existing measures..... The Approved Code of Practice is guidance.....[Employers] may use alternative methods....in order to comply with the law".[204] On 29 July 1999 the Health and Safety Commission published a consultation document seeking views on further action to control passive smoking at work which included an option for an Approved Code of Practice to "clarify what steps employers should be taking to protect their employees from the unpleasant effects of tobacco smoke, and to protect the health of those employees who suffer from a medical condition that could be made worse by exposure to tobacco smoke, such as asthma".[205] The Department told us that that consultation was now complete, and that if the Health and Safety Commission introduced the Code of Practice it would have a profound effect since "most public places are somebody's workplace".[206] We hope that the Code of Practice will be implemented in the House of Commons.

118. The Secretary of State told us that he was not in favour of introducing mandatory bans on smoking in public places. He felt that it was significant that voluntary agreements in place were with the hospitality sector, rather than the tobacco industry, and that it was in the commercial interests of

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[199] Ev., p.5.
[200] Ev., p.5.
[201] *Smoking Kills*, p.66.
[202] *ibid.*, p.69.
[203] *ibid.*, p.70.
[204] *ibid.*, p.72.
[205] Ev., p.5.
[206] Q161.

the sector to give people the right to a smoke-free environment.[207] He also told us that his officials would shortly be meeting representatives of the pubs sector to discuss definite targets for the provision of more non-smoking areas in pubs, and that the same procedures would then be followed with the restaurant sector.[208]

119. We understand the reluctance of the Secretary of State to pursue the path of legislation to secure smoke free environments in places of leisure. Nonetheless, it would appear that at present the consumer does not always have much choice and is only able to vote with his or her feet if there are alternative venues where a genuine smoke-free environment is available. When the Consumers' Association conducted its opinion survey it found that three quarters of its respondents were exposed to passive smoke in either the home, their place of work or places they visited socially and that on average these respondents were exposed to passive smoking in two different locations. Some 60% of those surveyed said that they were exposed to smoke in places they visited socially, whilst 20% experienced smoke in their place of work.[209]

120. In this context, we note the views of the National Asthma Campaign that cigarette smoking is a "highly common trigger" of asthma attacks and that people with asthma "have the right to breathe air that is clean and free of other people's tobacco smoke".[210] As we stated earlier, we do not regard asthma attacks as merely "annoying". We also regard as extremely serious the body of evidence supporting associations between parental smoking and Sudden Infant Death Syndrome.

121. **In our view, voluntary agreement on passive smoking cannot yet be said to be really delivering smoke-free environments to all those who want them. The very real improvements of recent years probably owe more to market forces than to any action by Government. Indeed, we believe that market forces will continue to be a significant driver for change in this area. On balance, we accept that in the leisure sector, voluntary codes may offer the best way forward. We would hope, however, that these yield much more effective action on the part of the hospitality sector than has been the case to date. In this respect, we believe it is essential that the Government sets out a strict timetable for the targets to measure performance cited in its White Paper.[211] Certainly, if the latest agreements do not significantly improve the situation we think the Government will have to consider what more stringent actions it could take. In respect of the workplace, we believe that the proposed Health and Safety Commission Code of Practice offers a good way forward.** Our greatest concerns, however, lie in the home, where babies, infants and older children are routinely exposed to ETS through no wish of their own.[212] This is also the most intractable area. All governments can do to improve the situation is to increase public awareness of the risks, and this is the strategy they have adopted. **We believe that even greater efforts need to be made throughout the primary care teams to educate adults on the dangers their smoking poses to children.**

122. We also regard as ill-considered and inappropriate the attempts of the tobacco industry to play down the risks of passive smoking. We are not inclined to view their opinions on the health risks of active or passive smoking as anything other than subjective. The track record of Philip Morris in particular, with its massively funded campaign to throw doubt on the science underlying research into passive smoking, indicates to us just how seriously the companies view the threat of widespread public acceptance of the risks of passive smoking.[213] While the dangers of passive smoking are far less than those attaching to active smoking they are not by any other standard trivial. As we pointed out to Mr Clark of FOREST, if a drug caused two or three deaths per hundred thousand it would be regarded as a very serious matter.[214] Even if the mechanisms of cause and effect are not yet known, and even if the precise magnitude of the added risk is hard to gauge, we see no reason why the public health authorities should not pursue the precautionary principle in respect of the potential risks from ETS.

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[207] Q1332.
[208] Q1332.
[209] Ev., p.504.
[210] Ev., p.491.
[211] *Smoking Kills*, pp.69-70.
[212] There is also evidence that "ETS among non-smoking pregnant women can cause a decrease in birth weight". See *International Consultation on Environmental Tobacco Smoke (ETS) and Child Health: Consultation Report*, World Health Organisation, 1999, Executive Summary.
[213] See Eliza K Ong and Stanton A Glantz, "Tobacco Industry efforts subverting International Agency for Research on Cancer's second-hand smoke study", *The Lancet*, vol. 355: 9211, 8 April 2000, pp 1253-59.
[214] Q625.

123. **We believe that a tobacco regulatory authority such as that we propose below in paragraph 189, with access to high quality scientific advice, would be the appropriate body to advise the Government on the evidence as to the health risks of passive smoking, possible measures to reduce its impact and even the potential benefits of innovative products which might reduce the amount of sidestream smoke which cigarettes emit.**

Measures to improve product safety:

The low tar programme

124. When discussing measures to make cigarettes 'safer', it needs to be remembered that cigarettes are inherently unsafe products: as the Government's White Paper puts it - smoking kills. The Chief Medical Officer (CMO) told the Committee that "There is no such thing as a safe cigarette. It is a highly dangerous and lethal product".[215] Although this is the case, there have been since the 1970s, and there continue to be, efforts made to minimise the harm caused from smoking or, to put it another way, to slow down the rate at which smoking kills. This is what we mean in this report when we refer to "safer" cigarettes; we agree with the CMO that there is no such thing as a safe cigarette.

125. All the cigarette company representatives from whom we took evidence accepted that there was no such thing as a 'safe' cigarette,[216] with the exception of Mr Gareth Davis of Imperial Tobacco, who said "I do not think that we can say that it is safe or it is unsafe".[217] **Tobacco companies should produce the least harmful product possible. We are totally unconvinced that Imperial Tobacco can be committed to producing such a product while its public stance is to refuse to accept that cigarettes are intrinsically unsafe.**

126. Efforts made to produce a 'safer' cigarette over the last three decades have focused almost exclusively on reductions in tar and nicotine levels in cigarettes, first by voluntary agreements between Government and tobacco companies, and subsequently by European legislation. In 1971 the Government appointed the Standing Scientific Liaison Committee on the Scientific Aspects of Smoking and Health (known as the "Cohen Committee"). Following an influential report by the Royal College of Physicians, *Smoking and Health Now,*[218] the Committee recommended that the tar and nicotine yields of all important brands of cigarettes should be published twice yearly, and analyses should be undertaken by the Laboratory of the Government Chemist. They also recommended that the public should be educated about the effects of tar and nicotine and be encouraged to switch to brands with a lower tar yield. Subsequently, the Government appointed the Independent Scientific Committee on Smoking and Health (ISCSH) in 1973, (which was succeeded by the Scientific Committee on Tobacco and Health (SCOTH) in 1994). The ISCSH produced four reports between 1975 and 1988, as a result of which the industry entered into a number of voluntary agreements, which continued the policy of lowering of tar yields in cigarettes.[219]

127. Tar and nicotine yields in cigarettes have been reduced considerably in the last 30 years, with UK sales weighted average tar yields falling from 20.8mg in 1972 to 10.28 mg in 1997, and nicotine yields generally falling in a similar way from 1.33mg to 0.8mg.[220] Each of the tobacco companies stressed their contribution in achieving this reduction via the voluntary agreements: Imperial stated that it has "made enormous efforts to assist the Government in achieving its objectives of lowering tar yields in cigarettes";[221] BAT said that "a powerful scientific consensus in favour of reducing tar existed in the 1970s and 1980s, and was supported in the UK by the Government. Indeed, it became the central plank of the product modification programme.... given effect through a series of voluntary agreements.... BAT was responsive to this consensus";[222] Gallaher stated that it had had "a committed response to the smoking and health issue and lowered tar yields, long before tar reduction came within the ambit of voluntary agreements...";[223] Philip Morris told the Committee that "we believe that we have properly responded to calls to reduce "tar" and nicotine yields and would be pleased to work with Government on this issue";[224] RJR said that it had "worked closely with the

[215] Q68.
[216] QQ393-400.
[217] Q397.
[218] *Smoking and Health Now*, 1971.
[219] Ev., pp.6-8.
[220] Ev., p.212.
[221] Ev., p.214.
[222] Ev., pp.142-43.
[223] Ev., p.180.
[224] Ev., p.230.

Government to conclude voluntary agreements relating to....ingredients and additives...".[225] In accepting the tar reduction programme, however, the companies successfully argued that they needed to be able to introduce additives into their cigarettes in order to maintain a flavour that smokers could enjoy.[226] We look at the consequences of this action at paragraph 153 below.

128. In addition to the voluntary agreements referred to, tar yields are now governed by European legislation. EC Directive 90/239/EEC, enacted in 1992, limited tar yields to a maximum of 15mg until January 1998 and 12 mg after that date.[227] The Commission's proposed Directive[228] will limit tar yields to a maximum of 10mg from January 2004 (or three years from the date of adoption).[229]

129. Experts are divided on the impact that lowering nominal tar yields has had on health. Epidemiology suggests that cancer rates have fallen faster than can be explained by changes in smoking prevalence and overall consumption of tobacco, and that therefore it is likely that the harm caused by each cigarette has reduced. This has occurred at the same time that nominal tar yields have been reduced through voluntary agreement and regulation, and the conclusion drawn is that tar reduction is responsible for the health improvement.

130. Others argue that each smoker controls their own nicotine intake and that this is largely independent of the reduction in machine-measured tar and nicotine yields. The Health Education Authority's evidence stated that "smokers' behaviour is determined largely by their need to consume nicotine. People smoking low tar, low nicotine cigarettes engage in 'compensatory smoking'. They take more puffs, inhale more deeply and block the vent holes in the filter.... Just three or four extra puffs on a cigarette can transform a low tar cigarette into a regular strength cigarette....".[230]

131. Evidence received from ASH and the RCN stated that "the main problem with the so-called 'low-yield' cigarettes is the quality of the measurements gathered using US Federal Trade Commission (FTC) machines. Although the results of these machines have been accepted as a global standard, it has recently been recognised by the FTC itself that readings from the machine significantly under-estimate the nicotine and tar intake of a 'real' smoker". This is largely because of 'compensatory' smoking habits, which allow smokers "to get as much nicotine as their addiction required. Compensatory habits included blocking ventilation holes with lips, fingers or saliva and taking more and deeper puffs. This resulted in an almost unchanged nicotine and, by implication tar, intake. Currently the air drawn through ventilation holes in the filters of 'low-yield' brands can account for up to 70% of the total intake. This means that a testing machine not designed to recreate smoking compensation, gets only 30% of the potential nicotine and tar intake of a smoker with compensatory habits".[231] A recent study found that this figure is, if anything, likely to be an underestimate, and that smokers' nicotine intake is double that of the machine-measured yield for cigarettes with the highest nominal nicotine yield, but that nicotine intake for smokers of cigarettes with the lowest nominal yield can take in 15 times the machine-measured yield.[232]

132. Evidence suggests that some parts of the tobacco industry at least have been aware of the impact of compensation for many years. A BAT memo from 1984 states that "Consumers may have been obtaining 14-16 mg PMWNF[233] (and normal equivalent nicotine delivery) for a very long time, i.e. compensating down to 16 mg when cigarettes delivered 25 mg and compensating up if they are now smoking a 13 mg".[234]

133. Those who believe that smokers completely compensate for nominally reduced levels of nicotine and tar in cigarettes and that the machine measurement does not reflect the true exposure of smokers to tar point to other changes in cigarettes made over the relevant period, such as more favourable ratios of nicotine to tar in the smoke and the greater use of reconstituted tobacco sheet with lower specific toxicity. It is argued that those changes have led to the modern cigarette, whatever its nominal yield, being less carcinogenic than cigarettes of the 1960s and 1970s and that they are not acknowledged sufficiently in the epidemiological assessments made of the relationship

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[225] Ev., p.236.
[226] Ev., p.66.
[227] Ev., p.112.
[228] COM (1999) 594 final.
[229] Greece has a continuing derogation until January 2007, or 6 years from the date of adoption.
[230] Ev., p.14.
[231] Ev., p.64.
[232] M J Jarvis, R Boreham, P Primatesta, C Feyerabend and A Bryant, *Machine-smoked brand nicotine yield and nicotine intakes in cigarette smokers: evidence from a representative population survey, (under consideration for publication).*
[233] Particulate matter water and nicotine free: a term for tar.
[234] *Proceedings of the smoking behaviour marketing-conference July 1984*, BAT, Minnesota trial exhibit 13,431.

between tar yield and health.

134. The Royal College of Physicians' recent report, *Nicotine Addiction in Britain*, stated that "there are.... reasonable grounds for concern that low tar cigarettes offer smokers an apparently healthier option while providing little if any true benefit". It also stated that "there is clear evidence that smokers misunderstand published machine-smoked yields and derive false health reassurance from them.... In so far as low yield cigarettes may discourage smokers who would otherwise have given up smoking completely from doing so, they may... be counterproductive in terms of public health".[235]

135. This view was supported by evidence presented by the Health Education Authority (HEA). In a recent survey of 3,448 adults (1,036 of them smokers), the HEA found that a third of all smokers smoked cigarettes described as 'light', 'mild' or 'ultra light'. It also found that most light smokers (over 77 per cent) switched from regular cigarettes largely because they see 'light' cigarettes as being less harmful, and that almost a third said that a main reason for switching was as a step towards quitting.[236] It recommended that the proposed EU Directive should curtail the use of the term 'light'.[237]

136. Evidence from ASH and the RCN was scathing about the tar reduction policy. It stated that "the development and branding of 'low-tar', light, mild cigarettes... offer the appearance but not the reality of reduced tar exposure. This has lent official endorsement to a confidence trick played on the consumers by the tobacco industry. The outcome has been to divert health concern about smoking into new brands offering false reassurance, rather than increasing the motivation to quit.... It has distracted from meaningful regulation that would have made a difference. While concentrating on 'tar', regulators have missed opportunities to force reductions in particular toxins, control the use of additives or subject cigarette engineering techniques to regulatory control".[238]

137. **Three charges are made against the tar reduction strategy. The first - that, mainly because of compensatory smoking, it is simply ineffective in making cigarettes less harmful - is disputed amongst experts. Although the evidence about compensatory smoking is convincing, it is difficult to reconcile this with the fact that deaths from smoking have fallen faster than can otherwise be accounted for during the period in which the policy was enacted. This latter point leads us to support the further reduction in tar levels in the proposed EU Directive and the further provisions made in the Directive to review the effectiveness of the tar reduction programme based on the best evidence available. We further recommend that the Tobacco Regulatory Authority which we want to see established should, as a high priority, examine the factors responsible for the reductions in death rates from smoking, with a view to establishing a firmer basis for regulating cigarettes in the future.**

138. **The two further charges are that actual or implied claims about beneficial health effects of low-tar cigarettes have lessened the incentive of people to give up smoking entirely; and that it has distracted from the other, potentially much more effective, regulatory options available. We take these two charges very seriously. In order to tackle the first, we recommend that the terms 'light', 'mild' 'ultra', 'low tar' and 'low nicotine' be proscribed by law in cigarette branding and marketing (by EU Directive, or by primary legislation in the United Kingdom). To tackle the second charge we recommend that the Tobacco Regulatory Authority which we propose at paragraph 189 be able to examine, propose and enforce innovative and effective alternative regulatory regimes. It is clear that a regulatory approach based on reducing nominal tar yields alone is inadequate.**

'Safer' cigarettes

139. As well as the tar reduction programme, other product modifications have been made to cigarettes in an attempt to make them 'safer' and some companies continue to try to produce and market such products. For example, Philip Morris told us about its Accord product which heats rather than burns tobacco, using a hand-held lighter.[239] They said that the product was "notable because it has significantly lower amounts of various constituents found in tobacco smoke. For

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[235] *Nicotine Addiction in Britain*, p.135.
[236] Ev., p.15.
[237] Ev., p.17.
[238] Ev., pp.66-67.
[239] Q391.

example, in comparison with a standard reference cigarette, Accord provides significant reductions in carbon monoxide, aromatic amines, benzene and polyaromatic hydrocarbons".[240]

140. Unfortunately, the commercial precedents for such innovative cigarettes are not promising. For example, R J Reynolds launched *Premier* in the US, as a "new technology" cigarette, which heated rather than burned tobacco. However, their evidence stated that "consumers did not respond favourably to the product in trials in the US and *Premier* was consequently not put onto the UK market." Two other similarly innovative products failed market research tests. R J Reynolds stated that "a major contributory factor to the failure of the products described.... was [RJR's] inability to communicate the products' potential benefits to consumers".[241]

141. Gallaher told the Committee that "in July 1977, [it] launched four cigarette brands containing a substitute material named Cytrel. None of these brands....were commercially successful". It suggested that the reasons for this failure were:

> "(a) the word 'substitute' had to be printed on the packet;
> (b) the product was taxed at the same level as cigarettes containing no substitute materials...
> (c) The Health Education Council [the predecessor of the HEA]...undermined the product by advertising against it."[242]

142. Imperial's evidence stated that in the 1960s it started developing an unflavoured, nicotine-free smoking material known as NSM. In 1977 it launched six brands of cigarettes containing 25% NSM and 75% natural tobacco. However, it said that there was a lack of consumer demand and that the brands' failure could be attributed to: the Government's refusal to reduce levies on NSM products in relation to conventional cigarettes; adverse effects as a result of Government sponsored campaigns; and the fact that "cigarette smokers preferred conventional cigarettes".[243]

143. The reasons given by the tobacco companies for the failure of such "safer" products were in contrast to those suggested by ASH and the RCN. Their evidence stated that "the annual smoking death toll could be significantly reduced if cigarette manufacturers used their vast and detailed knowledge of the design and processes involved in the manufacture of their product to reduce its toxicity and carcinogenicity".[244] As evidence for this they referred to 57 patents taken out by tobacco companies which, they argued, could reduce the hazardous chemicals in cigarette smoke. They gave four reasons why they believed companies had not produced 'safer' products: legal (such a move would be an admission that other products were unsafe); marketing (a safe product might make the unsafe equivalent unappealing); economic (the costs of producing and marketing a new product); and regulatory (by showing that certain chemicals could be controlled, the companies might be inviting regulatory 'intrusion' which could force change).[245]

144. The contrasting reasons put forward for the failure - so far - of 'safer' cigarettes raises the issue of whether companies should be able to work in a 'looser' regulatory environment for such goods, for example, in terms of the claims used when marketing them. The RCP's report recognised the complexities of the situation: "Were these products to be marketed with promises, direct or implied, of substantially reduced risk to health, sales might be expected to rise substantially..... However, these novel nicotine delivery devices raise a number of regulatory concerns. One important question is whether the products have less toxicity than conventional products..... More difficult to answer, though, is the nature and extent of any long-term problems. Chronic toxicity may not be revealed in short-term tests, and products such as these could conceivably - as with 'light' cigarettes - make the problem worse".[246] The Secretary of State also recognised the problem of needing a long-term assessment of the impact of particular types of cigarettes.[247]

145. The RCP also stated that consideration would have to be given to the regulation of 'safer' cigarettes alongside that of medicinal forms of nicotine because of the interrelated issues. The report concluded that one approach "might be to grant preliminary approval for marketing of products such as these, based on a range of information and assurances from the manufacturers. Post-marketing

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[240] Ev., p.230.
[241] Ev., pp.235-36.
[242] Ev., p.178.
[243] Ev., p.213.
[244] Ev., p.65.
[245] Ev., p.65.
[246] *Nicotine Addiction in Britain*, pp.172-73.
[247] Q1399.

studies by the manufacturer would be required so that adverse effects on public health could be detected and promptly corrected".[248]

146. **Given that, because of their addiction, people will demand cigarettes for the foreseeable future, it is clearly preferable that they smoke 'safer' cigarettes. We therefore hope that such products will be developed. We note the argument put forward by some of the companies that the successful marketing of such products is stymied by the regulatory framework. We recommend that the new Tobacco Regulatory Authority which we want to see established should have powers to review and approve applications from companies to market such products in a way which conveys their potential benefits compared to normal cigarettes, as long as full information about the product is provided and assessed by an independent panel of experts (appointed by the Authority), a process which should be funded - via a charge by the Authority - by the company applying. There should then be regular and rigorous reviews of the product and its effects to ensure that it deserves to retain its preferential marketing status. We would expect that status to be very narrowly defined and its promulgation strictly enforced by the Authority.**

Additives

147. Gallaher defined additives as "those substances other than water, which are added to tobacco products in the course of manufacture and which are intended to be burnt when products are smoked".[249] Until 1970 the use of additives was subject to long-standing restrictions imposed for "revenue reasons".[250] The Finance Act 1970 provided for tobacco duty to be charged on additives; however, it was not until 1978 that restrictions were finally lifted and statutory control of additives ceased.[251] The ISCSH was given the task of drawing up guidelines for the testing and marketing of additives which it produced in its First Report issued in 1975.[252] The then DHSS began maintaining an approved list of additives (the "permitted list") which specified the maximum usage for all additives.

148. The permitted list currently allows over 600 additives. Gallaher describes these additives as being "strictly regulated" but that is not an interpretation we believe the evidence can sustain.[253] More accurate, in our view, was the assessment of the Faculty of Public Health Medicine who described the regulatory frameworks as "wholly unsatisfactory".[254] They argued that although the additives were generally screened for their toxicity "by ingestion" no separate testing was carried out "under conditions of burning and inhalation". They went on to suggest that the sole function of some additives appeared to be to enhance the nicotine "hit".[255]

149. The DoH described other problems with the current regulatory framework. First, the UK is obliged to permit the use of any additive approved for use elsewhere in the EU "provided they have been assessed by a recognised scientific body". But EU countries vary widely in their protocols for determining which additives are permissible.[256] Second, there is "no compulsion" for the companies to reveal the purpose of the additive; this is merely "desirable".[257] The Department also cited a recent article in the journal *Tobacco Control* in which it is suggested that, before an additive is licensed for use, it should "meet a test of public health or public interest" and there should be an evaluation of the "overall public health impact of the use of an additive".[258]

150. In oral evidence the Department drew our attention to proposals in the draft EC Directive to ensure that by the end of 2003 all manufacturers and importers of tobacco products would have to notify member states of the quantities of each additive included together with a statement indicating the reason for inclusion of each ingredient and data on the impact of these additives in burnt and unburnt form to show they were safe.[259]

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[248] *Nicotine Addiction in Britain*, p.173.
[249] Ev., p.182.
[250] Ev., p.6.
[251] Ev., p.6.
[252] Ev., p.6 and p.182.
[253] Ev., p.182.
[254] Ev., p.641.
[255] Ev., p.641.
[256] Ev., p.8; Q1325.
[257] Ev., p.8.
[258] Ev., p.8.
[259] Q88.

151. The Department also cited a document jointly produced by ASH and the Imperial Cancer Research Fund which claimed that the internal documents of the US tobacco companies indicated that their research had enabled them to use additives "to perfect the engineering of the cigarette" as a "very efficient drug (nicotine) delivery system".[260] The Chief Medical Officer expanded on some of the potential health problems additives might cause. He argued that additives might be hazardous to health "in their own right", might affect the smoke chemistry which would be particularly a matter of concern in respect of carbon monoxide and cadmium, might create free-based nicotine making the cigarette more addictive, and might, by increasing palatability make the cigarette more "desirable". He went on to suggest that sweeteners and chocolate, which were reportedly sometimes added, could make cigarettes "more palatable to children", cocoa might dilate the airways allowing larger amounts of tar to enter the lungs, additives might mask the smell of smoke to make it "more socially acceptable" and finally additives such as ammonia might predispose people to other illnesses.[261]

152. Mr Wilson of Gallaher pointed out to us that in the Virginia-tobacco based UK cigarette "hardly any additives are used", a point expanded upon in written evidence, where Gallaher pointed out it used only six additives in most of the cigarette brands it manufactures for sale in the UK.[262] Both BAT and Philip Morris strongly disputed claims that individual additives had the function of increasing the nicotine hit or encouraging underage smoking. For example, Philip Morris refuted the suggestion made by ASH that ammonia was used to increase the effect of nicotine. They added that they did not design cigarettes to increase the acetaldehyde levels in smoke and that no credible data existed to suggest that acetaldehyde in smoke was addictive or increased the effect of nicotine.[263] BAT offered a detailed rebuttal of ASH's allegations over the effect of particular additives. They dismissed out of hand claims made by ASH as to the purpose of additives, such as the suggestion that cocoa, containing theobromine, might have a bronchodilatory effect, or that ammonia boosted the nicotine delivery to smokers. They described the ASH evidence in this respect as "inflammatory and misleading".[264] At our meeting with BAT scientists in Southampton further detailed answers were given to counter the ASH allegations. BAT also assured us that it had engaged in discussions and presentations to the Department of Health and told us it would like its dialogue to continue so that it could meet the "Tobacco Policy Unit soon to find a sensible way forward".[265]

153. We strongly support the view of BAT that "objective scientific appraisal" should be the basis for regulation of additives but we do not believe that this currently applies. We believe that regulation of additives should take into account the overall public health impact of additives. For example, Dr Dawn Milner, the Senior Medical Officer in the Tobacco Research Unit of the DoH, told us that in the 1970s the Government had had to agree to requests from the tobacco companies to include more additives to make low tar cigarettes more palatable to consumers. But the inclusion of such additives - given the current debate over the actual health impact of 'lower' tar - should now, in our view, be subject to review. We are not the appropriate body to judge whether ASH or BAT is right in respect of their claims and counter-claims over the role of additives. Given the pitiful resources it dedicates to scientific research on tobacco control (see paragraph 198 below) we cannot believe that the DoH itself is well placed to make a judgement. In fact we believe that the idea of teams of BAT scientists offering presentations to poorly-resourced civil servants potentially represents a continuation of the highly unsatisfactory situation of the past 25 years, amounting almost to regulatory capture, in which the industry has been able to run rings round poorly-resourced civil servants.

154. We welcome the fact that the proposed EU directive requires manufacturers to submit evidence on the purpose of additives and their impact in both burnt and unburnt form, but we do not think that these measures go far enough. The Secretary of State told us that he thought there had to be "an independent scientific committee" at European level to assess the issues arising out of additives.[266] **We believe responsibility for licensing additives permitted for use in tobacco products sold in the UK should be passed to the Tobacco Regulatory Authority we propose below. We further believe that this body should take account of the overall public health impact of the inclusion of an additive in determining whether or not it should be permitted for use in tobacco products**. So if an additive is toxicologically harmless in itself, but in some way

[260] Ev., p.9.
[261] Q84.
[262] Q478; Ev., p.182.
[263] Ev., pp.230-31.
[264] Ev., p.158. For the detailed response to the ASH claims see especially BAT's evidence at pp.580-84.
[265] Ev., p.584.
[266] Q1320.

exacerbates the addictiveness of nicotine or makes cigarettes more palatable for children, we believe it should be banned.

155. The current regulation of additives is weak in another respect: neither the Department of Health nor the consumer has any idea which additives can be found in which products. After almost a year's delay the companies have, recently, submitted to the DoH a list of additives used in their brands. In the Secretary of State's view the limited information recently given was prompted by our current inquiry.[267] However, the brands in most cases were anonymised and given on a coded basis.[268] The Secretary of State told us that in his view the companies should be obliged to pass on information on the additives by brand to his Department, to us and to the consumer.

156. We felt it was completely unacceptable that information on additives by brand has been withheld for so long. So we required the companies to submit this information to us. The five companies from whom we requested oral evidence all duly submitted this material, though all considered it "commercially confidential". Imperial, however, told us it intended to make this material public shortly on its website.[269] We are not at all convinced by the argument for commercial confidentiality. As our Irish counterpart Committee pointed out, it would be perfectly possible for rival companies to establish what ingredients are included in cigarettes by a process of reverse engineering.[270] Even if this were not the case we believe that this is another area in which normal commercial rules should not apply.

157. Accordingly we have chosen to publish in full, brand by brand, the list of additives formerly submitted in anonymised form to the Department of Health. For the first time the UK consumer will be able to learn what exactly he or she is smoking. For example, someone smoking Lucky Strike King Size Filter Tip might be surprised to discover that, apart from tobacco, the product contained such things as sucrose and sucrose syrup, honey, licorice root, carob bean extract and diammonium hydrogen phosphate. Benson and Hedges Mellow Blend King Size has amongst its ingredients, sorbitol, caramel, dried fruit extracts, ethylene vinyl acetate copolymer and benzoic acid. Camel Lights offer such additives as glycerol, honey, maple syrup extract and concentrate and magnesium oxide. Marlboro King Size (Fliptop Box), amongst 20 or so ingredients, provides cocoa, cocoa shells and extract, cocoa distillate and butter, 4-Hydroxy benzoic acid propylene glycol and diammonium hydrogen phosphate.[271]

158. **We think that the position of the tobacco companies in withholding information on the additives their cigarettes contain is completely untenable. Consumers have a right to know what they are smoking, including the percentage of the product such additives form, and we believe that this information should be available on every packet. We believe the companies should immediately take steps to ensure this is done and that the Secretary of State should introduce measures to make such labelling a mandatory requirement for cigarettes sold or manufactured in the UK.**

Other measures to reduce and deter consumption

Price

159. The primary weapon of Government action to reduce smoking has for many years been price. In its memorandum the Department concluded: "it is generally recognized on all sides that the single most effective policy for reducing tobacco consumption is price. Successive governments have therefore regularly raised excise duty on tobacco products as a means of discouraging consumption." They suggested that the current Government has committed itself to raising tobacco duty by 5% per annum in real terms.[272] Since 1993 successive Chancellors have indicated that they propose to increase the duty on tobacco products by a sum greater than the rate of inflation. The current Chancellor of the Exchequer in his 1999 Pre-Budget statement, however, indicated that this policy was not now guaranteed.[273]

160. The tobacco industry has argued forcefully that the great disparity in price as between the UK and the rest of EU has given great incentives to bootleggers. In turn they suggest that much of the

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[267] Q1320.
[268] Gallaher and Philip Morris provided material to the DoH by named brand, a move we welcome. See Ev., pp.597, 622.
[269] Ev., p.614.
[270] Joint Committee on Health and Children Report, *A National Anti-Smoking Strategy*, p.69.
[271] Ev., pp.596, 599, 619 and 627.
[272] Ev., p.5.
[273] *Pre-Budget Statement (1999)*, p.94.

tobacco distribution in the UK goes through unregulated channels in that bootleggers are unlikely to exercise much scruple in selling their products to children. Imperial told us that it estimated that cross-border trading now comprised at least 80% of hand rolled tobacco sold in the UK and at least 20% of cigarettes.[274] The counter arguments put forward by ASH is that the great majority of tobacco smuggling comes not by means of the "white van trade" but through highly organized large scale activity; and that smuggling also occurred in low duty countries.

161. We endorse the Government's strategy in using price as a weapon of tobacco control although we believe that a number of factors need to be taken into account in pursuing this strategy. Firstly, as we have noted previously, smoking is already an activity strongly skewed towards the poorest groups in society. The addictive nature of nicotine means that this product is not one that the poorest smokers can easily sacrifice. So we believe that if this strategy is not to add to the social and health inequalities which smoking generates, the highest priority will need to be given to other smoking cessation services targeted at these individuals.

162. Secondly, we believe that if the Government is to make price its main weapon against smoking there needs to be a more explicit recognition that the duty increase is a health-promotion tax. We were surprised that the Department's officials had conducted no systematic analysis of the costs of smoking to society as a whole in the UK.[275] We asked the Department to estimate the social costs of smoking and they arrived at a figure of £2.32 - 2.35 billion per annum to cover fire damage to property, the costs of treating disease caused by passive smoking, the costs of treating smoking related diseases amongst current smokers and invalidity benefit relating to smoking related diseases. The Department admitted this analysis was "patchy".[276]

163. In terms of the income tobacco products yield in the UK the figures are not in dispute. HM Customs and Excise collected £8.2 billion in tobacco revenues in 1998/99.[277] It is within this context that we think the views of Dr Yach, Programme Manager of the WHO's Tobacco Free Initiative, need to be assessed when he told us "we find ... that when there is earmarking of tax for tobacco control activities, you have greater levels of public acceptance and you have a sustained institutional capability in countries to continue tobacco control beyond the pricing mechanism ...".[278] The Chancellor has, recently, shown himself willing to hypothecate some of the additional moneys accruing from the duty increases on tobacco towards the NHS. In his Budget Statement in March 2000, the Chancellor raised cigarette taxes by 5 per cent above inflation (25 pence per packet) and said that "every penny of the extra revenue....[would go] to funding our hospitals and the National Health Service".[279] We believe that, given the huge imbalance between the amounts the Treasury receives from smokers and the amount it spends on treating diseases caused by tobacco and on smoking cessation, the Government should earmark some of the increased tobacco revenues *directly* for smoking cessation strategies. We also believe that the Government needs more precise data on the actual costs of smoking to society.

164. If imbalances in tobacco duties between different EU countries prompt smuggling we believe this is a matter for law enforcement agencies. HM Customs and Excise itself estimates that £2.5 billion of revenue was lost as a result of tobacco smuggling.[280] The Government recognises that tobacco smuggling is on a "strong upward trend" and has designed a strategy to tackle it. This strategy consists of: a national network of scanners to detect high volume smuggling in freight containers; marks on packs to make identification of smuggled goods easier; tougher punishment for convicted smugglers; more customs officers; and a publicity campaign to raise public awareness.[281] The Government has committed up to £209 million over the next three years for extra staff and resources for Customs. This will fund up to 950 extra staff devoted to combating tobacco smuggling. Although these figures are not yet finalised, an immediate allocation of an additional £30 million each year from 2000-01 was announced in March 2000.[282] The Government hopes that this will "slow the growth of smuggling in the next financial year, and ... put smuggling into decline in the third year".[283] It estimates the new measures will result in an extra £2.25 billion being collected in

[274] Ev., p.223.
[275] QQ52, 55.
[276] Ev., p.490.
[277] *HM Customs and Excise Annual Report 2000*, Cm 4616, p.22.
[278] Q293.
[279] *Official Report*, 21.3.00, c 869.
[280] *Tackling Tobacco Smuggling*, HM Customs and Excise, HM Treasury, March 2000, p.5.
[281] *ibid.*, p.1.
[282] *ibid.*, p.11.
[283] *ibid.*, p.11.

revenues and VAT over the next three years.[284] **We do not believe it would be appropriate for health policy to be shaped by the activities of criminal gangs. With this in mind we welcome the additional funding the Treasury is providing to boost Customs and Excise in their efforts to secure compliance with the law.** In Section IV below we discuss the role of two tobacco companies in respect of charges that they were implicated with tobacco smuggling.

Education and information to consumers

165. In its memorandum the DoH pointed out to us that "successive governments have also invested in education campaigns warning consumers of the dangers of tobacco products".[285] The Minister for Public Health told us that the Department had recently "massively increased the budget for campaigning" and that a three year, £50 million new campaign had just been launched, which included television advertisements, billboard posters and telephone support lines.[286] **We welcome the fact that the Government has launched its ambitious recent campaign. We are not, however, convinced that the Government has enough knowledge of the reasons why people smoke to make such a campaign fully effective.**

166. The Minister for Public Health also assured us that the disbandment of the Health Education Authority (who gave oral evidence during our inquiry) to be replaced by the Health Development Agency did not represent any downgrading of the public health anti-smoking resource, and that the HDA would work towards more "evidence based" campaigns.[287] **We welcome this assurance.**

167. Information to consumers has for almost 30 years also been provided in the form of health warnings printed on cigarette packets (from 1971), and later on other advertising and promotional material.[288] The warnings, which began with the wording "WARNING by HM Government. SMOKING CAN DAMAGE YOUR HEALTH", have altered over the years. The Tobacco Products Labelling (Safety) Regulations 1991 were required following a European Council Directive which established a general warning to be carried on all unit packaging of all tobacco products, and additional warnings exclusively for cigarettes.[289] Other information made available to consumers includes, as we have seen, the machine tested levels of tar and nicotine.

168. The Chief Medical Officer (CMO) told us that evidence suggested that "warnings do make a contribution to stopping people smoking" but that they did not account for a "big percentage of behaviour change". Warnings were less effective in children than in adults and benefited from being frequently changed so that people did not simply switch off when they saw them.[290] We asked the CMO if he thought there should be emphasis on cancers other than lung cancer and he agreed that it would be helpful if more people were aware of the contribution tobacco made to oral cancers.[291] He also told us that the Health Education Authority's recent advertising campaign, drawing attention to the effects of smoking on the ageing of women's skin, had been "highly effective" with young women.[292]

169. We are, again, not convinced that the health education authorities can target their audience effectively without greater knowledge of what motivates people to smoke. **We would draw the attention of health education authorities to the materials we have uncovered from the advertising agencies relating to the motivations of young and adult smokers. We believe that if this material were to be analysed carefully it could yield important information which could be used to dissuade people from smoking.**

170. The health warnings themselves are partly a matter for the EU. **Nevertheless we think it important that the information provided by public health authorities on cigarette packets, and given out in public health campaigns (in schools, workplaces, via primary care or through other media) adopts a greater variety of messages and conveys information not yet addressed in the health warnings. We believe that the general assertions that "smoking causes heart disease" or "smoking causes lung cancer", whilst having a place in an overall educational strategy, are not in themselves sufficient.**

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[284] *ibid.*, p.12.
[285] Ev., p.6.
[286] Q1268.
[287] Q1268.
[288] See eg Ev., pp.200-203.
[289] Ev., p.5.
[290] Q169.
[291] Q173.
[292] Q169.

171. In its market research the Consumers' Association concluded that "most people are aware that smoking carries health risks" but that "awareness of some smoking-related conditions was higher than for others". In particular, they noted that "the increased risk of cardiovascular disease ... was not well recognized".[293] Given that heart disease kills more smokers than lung cancer this seems to us an alarming finding.

172. **We believe that the Department of Health should instigate a much more comprehensive and sophisticated educational programme. From our meetings with public health groups in America we think it is vital that young people should themselves be actively involved in dissuading their peers from smoking.** The Roy Castle Lung Foundation, which has particular expertise in the area of smoking and young people, suggested "peer to peer education by young people about tobacco is likely to be much more effective than lectures and admonitions from adults".[294] **We believe that messages for young people, who are often not impressed by arguments that their life will be shortened by smoking since death for them seems such a distant prospect, should range from information on the way smoking makes them less desirable socially to the ways in which tobacco makes poor people poorer. For example, the fact that smoking can damage skin and teeth should be made clear. There is also evidence that male potency can be damaged by smoking.[295] This is a particularly strong message for young men and we recommend that the Government and health authorities make greater use of it when communicating the dangers of smoking. We further recommend that this message be included as one of the health warnings on packs.**

173. **So far as adults are concerned, it is our view that the Department should take account of the fact that smoking is skewed towards those in poorer and less well educated households, as the advertising agencies do in many of their campaigns (see above). We believe that the Department should examine the ways in which the agencies have marketed their advertising to this sector and copy some of their most successful strategies. We think it important that public health authorities, as well as conveying the risk of smoking attempt to convey the *magnitude* of the risks of smoking, in terms of stressing, for example, the numbers of years of life lost by an average smoker or the fact that smoking kills half of all lifelong smokers, and half of those before the age of 69. We think it important that adults should be much more aware of the benefits of quitting in respect of the surprisingly rapid health gains, not least in terms of the speedy improvement in likely life-expectancy that quitting yields.**

174. For all age groups and all social classes, **we believe it is essential that the packet contains clear and effective labelling to the effect that tobacco products are drug-delivery devices creating addiction through nicotine**; we note that the Chief Medical Officer told us he thought it would "help a great deal" to draw attention to the addictive effects of nicotine.[296] **We also believe that packs should have a contact number to gain access to NHS smoking cessation advice and programmes,** a suggestion mooted by the Health Education Authority.[297] **Messages should appear on *all* packs, stating the addictiveness of, and damage to health caused by smoking. In addition, a variety of health messages - such as that relating to male potency which we recommend above - should be used on certain packets. These messages should be harder hitting and more relevant to consumers than those currently used.**

Nicotine Replacement Therapy and other treatments

175. Nicotine replacement therapy (NRT) aims to break smokers' dependency on tobacco products by offering them moderate levels of nicotine to alleviate withdrawal symptoms and breaking the association between smoking and nicotine.[298] Gum containing nicotine was first marketed in the UK in 1981; in the 1990s patches, nasal sprays, inhalators and sublingual tablets have all become available.[299] Nicotine replacement therapy is currently available within the NHS free for one week to those entitled to free NHS prescriptions, following trial provision in the Health Action Zones.[300]

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[293] Ev., p.510.
[294] Ev., p.501.
[295] www.ash.org.uk/papers/impotent.html
[296] Q42.
[297] Q76.
[298] *Nicotine Addiction in Britain*, p.143.
[299] Pharmacia and Upjohn Discussion Paper 1, 1999, p.9; *Nicotine Addiction in Britain*, pp.145-46.
[300] Q1272.

176. We asked the DoH for their views on the efficacy of NRT. Mr Baxter told us that NRT "doubles the success of any quit attempt regardless of the intensity of intervention" and was "an effective route to smoking cessation" provided the treatment was followed for its full course.[301] Dr Milner expanded on this to indicate the range of possible effectiveness: if the intervention was simply "brief advice" from a GP plus NRT the effectiveness increased from 2% to 4%; if the patient attended a smoking clinic with regular group therapy sessions with follow up and relapse sessions, quit rates of over 20% might be achieved.[302] The Secretary of State also suggested that NRT worked best within a "structured programme". He added that "even within a structured programme the evidence suggests that it will benefit a maximum of around 25 per cent of people who give up smoking".[303]

177. A number of individuals and organizations criticized the restrictions placed on the availability of free NRT on the NHS. Sir Alexander Macara, former Chairman of the BMA Council, told us that it seemed "very regrettable that the ability for doctors to prescribe for their patients an effective drug which would really effectively help them is so restricted".[304] Professor John Britton of the RCP also took issue with the number of restrictions placed on NHS availability of NRT, suggesting that NRT was "one of the most cost effective medical treatments available", with estimated costs in the range of £200 to £800 per life year saved.[305] The Pharmacia and Upjohn Discussion paper describes the NHS policy of one week's free supply for exempt individuals as having "limited credibility amongst informed audiences".[306]

178. We asked Ministers what the rationale was for limiting NRT to one week's supply. The Minister for Public Health told us that NRT was provided free for the first week since that was the "toughest week" for those wishing to quit; thereafter the costs of purchasing NRT, which amounted to £15.50, was "comparable" to the costs of buying cigarettes.[307] We put it to the Secretary of State that this argument might appear logical but that limiting free NRT to a week's supply might well, in the end, be poor value for money. It seemed to us that the pull of nicotine addiction was likely to be very high at the end of the first week; whilst smokers would then make any number of sacrifices to obtain cigarettes, which they craved, they would be less likely to make the 'rational' decision to purchase the NRT alternative.[308] One Health Action Zone, that in Tyne and Wear, told us that its experience led it to conclude that a week's free supply was "not sufficient" since "it cannot be assumed that the money saved by not buying cigarettes in the first week will be used to buy NRT in the second and so on".[309] The Secretary of State conceded that these were "reasonable points" but argued that the UK was already ahead of anywhere else in the world and was, effectively, conducting an "enormous public trial" of the efficacy of NRT.[310]

179. We asked the Department what the current costs of the NHS NRT programme were and what the costs would be of making NRT freely available on the NHS. We were told that the costs of the current programme were £7.5 million over three years and that extending NRT to make it freely available on the NHS would cost £84 million.[311]

180. Professor Britton of the RCP suggested that one way forward might be to make free NRT conditional on "a certain point of success" in that most people who failed did so relatively quickly.[312] We believe there would be considerable merit in making NRT available on the NHS. However, we doubt whether the current policy of providing free NRT for one week establishes the crucial link between smokers wishing to quit and the Primary Care Team. We look forward to seeing an evaluation of the work being done in Health Action Zones with NRT. **If NRT is shown to increase smokers' motivations to quit, we believe the Government should consider making NRT available on prescription[313] - available from smoking cessation clinics - for two weeks at a time, up to a maximum of six weeks in total.** We also believe that once General Practitioners are able

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[301] Q120.
[302] Q120; see further Q1299 and Q378.
[303] Q1277.
[304] Q367.
[305] Q371; see S Parrott *et al*, "Guidance for commissioners on the cost effectiveness of smoking cessation interventions", *Thorax*, 1998:53 (Suppl 5, Pt 2).
[306] Pharmacia and Upjohn Discussion Paper 1, p.26.
[307] Q1276.
[308] QQ1293-99; Q1302.
[309] Ev., p.536.
[310] Q1299.
[311] Q126, Q1280 and Ev., p.588.
[312] Q370.
[313] This would mean that smokers currently receiving free prescriptions would not have to pay for NRT for a period of up to six weeks.

to prescribe NRT on the NHS this will motivate them to offer more comprehensive smoking cessation services.

181. We further suggest that the Government may need to address other anomalies relating to the prescribing of NRT. For example, Tyne and Wear Health Action Zone pointed out that "there are problems in promoting NRT as an aid to smoking cessation within some target groups because of the contra-indications to NRT, which include severe cardiovascular or cerebrovascular disease and pregnancy." Also, "NRT is not licensed for children". We agree with the Tyne and Wear Health Action Zone that "the risks of smoking outweigh the adverse effects of NRT".[314] The same issues raised by NRT are also likely to occur in respect of an emerging class of oral therapies. Evaluation of such therapies should be an important task for the National Institute for Clinical Excellence.

III NICOTINE ADDICTION AND REGULATION

182. The author of a discussion paper, *Smoking, Nicotine and Society*, produced for Pharmacia and Upjohn, describes the way in which nicotine works:

> "Nicotine works at sites in the brain which are normally activated by the neurotransmitter ... acetylcholine. This in turn alters the levels of other natural neurotransmitters, including nor-adrenaline, dopamine and serotonin. They are involved in the functioning of the brain, and mood. Low levels of nor-adrenaline are, for example, associated with depression.
>
> Taking nicotine has a range of potential effects. In people who have not developed dependence the dominant response may be one of pleasure. This is probably associated with increases in the dopamine levels in a part of the brain known as the limbic reward system. But those who have adjusted to nicotine (by, for example, changing the number of receptors for key neurotransmitters) may need to keep taking it simply to avoid distress which occurs when levels drop too low."[315]

183. The RCP in their recent report on nicotine addiction in Britain commented: "the presence of nicotine is necessary but not sufficient. Tobacco smoke inhalation is the most highly optimised vehicle for nicotine administration because absorption through the lungs delivers nicotine to the brain rapidly and intensively".[316] The papers disclosed in the Minnesota litigation demonstrate that many tobacco companies have long understood that nicotine addiction lies at the heart of the reason why people smoke. According to the Faculty of Public Health Medicine, tobacco companies know that "cigarettes would not remain viable products without nicotine",[317] and that tobacco smoking is the most efficient way of satisfying this addiction. The Pharmacia and Upjohn paper explained that this form of drug delivery "allows the smoker to experience and control immediate rewards, and is highly addictive". The author went on to suggest "in the same way that 'crack' cocaine is much more dependence inducing than cocaine taken via, say, coca leaf tea, nicotine in inhaled smoke is more addictive than nicotine taken in other ways".[318] This mechanism undermines the claim made by Gallaher that, if people smoked cigarettes solely to obtain nicotine "every cigarette smoker who uses nicotine chewing gums, inhalers or patches would stop smoking".[319] As the RCP noted:

> "The speed of nicotine delivery is a fundamental difference between cigarettes and NRT products which deliver nicotine at lower and slower subaddictive rates. For this reason, nicotine delivered through tobacco smoke should be regarded as a powerfully addictive drug and smoking as a means of nicotine self-administration. The risk of addiction to NRT products is very low ..."[320]

184. The true nature of the addictiveness of tobacco products has only gradually been recognized by public health authorities. As has already been noted, Gallaher drew attention to the fact that in 1964 the US Surgeon General defined the "tobacco habit" as "an habituation, rather than an addiction"[321] but by 1988 the same body described cigarettes as "addicting", going on to say that "the pharmacological and behavioural processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine". We have also previously drawn attention to Mr Martin Broughton of BAT's description of nicotine as having a "mild" pharmacological effect,

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[314] Ev., p.536.
[315] Pharmacia and Upjohn Discussion Paper 1, p.7.
[316] *Nicotine Addiction in Britain*, p.185.
[317] Ev., p.639.
[318] Pharmacia and Upjohn Discussion Paper 1, p.7.
[319] Ev., p.183.
[320] *Nicotine Addiction in Britain*, p.184.
[321] Ev., p.184.

similar to caffeine.[322] In our view this is both a dangerous and inaccurate statement. We were struck by recent research conducted at the John Hopkins University School of Medicine which compared the subjective and physiological effects of intravenous administration of nicotine and cocaine.[323] The key finding of this study was that, when given these drugs double blind, subjects frequently misidentified nicotine as being cocaine, or, at high dose, as an opiate. The study reported "At all three doses, cocaine was identified as a stimulant by the majority of subjects. Nicotine was also identified as a stimulant by 80% and 50% of the subjects at the intermediate and high doses, respectively."[324] The study goes on to say it is interesting that "when subjects were asked to identify the type of stimulant they had been administered, subjects usually identified both cocaine and nicotine as being cocaine or amphetamine and almost never identified either drug as being nicotine"[325] even though the subjects were familiar with both cocaine and nicotine. Nicotine produced a "rush" and a "high" that was dose-related and if anything greater than nicotine.

185. We submitted this article to BAT for comment, at their request. BAT, in their attempt to refute it, quoted selectively from the small print of the study's findings to support their view that "the study reported clear substantive differences between cocaine and nicotine and expressly stated that point".[326] This is hardly the point. It is evident that cocaine and nicotine have different effects - in particular, as the report points out and as BAT quote, nicotine produces more jittery and aversive effects while cocaine has consistently more pleasurable effects. The reason we cited this evidence was that, when the usual cues of a lit cigarette were not present, users found it difficult to discriminate between nicotine and cocaine or an opiate. They could have rated nicotine as being like caffeine, which would have fitted in with Mr Broughton's theories, but they did not. They perceived it to have a pharmacological effect similar to, perhaps even stronger than, cocaine.

186. We also cited the recent RCP report on *Nicotine Addiction in Britain*. BAT took issue with this report's central conclusion that nicotine is "highly addictive to a degree similar or in some respects exceeding addiction to 'hard' drugs such as heroin and cocaine".[327] Rather than providing a detailed and reasoned critique of the careful scientific review and analysis underlying a report produced by an extremely eminent group of individuals, BAT contented themselves with a series of superficial comments, and stressed that nicotine and hard drugs differed both in terms of the extent to which they produced intoxication and in their legal and social contexts. They objected to comparisons between drugs which indicate that quit rates and relapse for nicotine are even lower than from heroin or cocaine, which they described as "an illogical comparison since a relapse to smoking does not have the same personal and social consequences as a relapse to heroin, cocaine or alcohol".[328] This we find a fairly startling conclusion: it is hard to imagine more severe personal consequences than major diseases carrying a high risk of death.

187. Yet, as if to emphasize more poignantly and effectively the true - and to most people self-evident - nature of tobacco's addictiveness, about 50% of patients who survive an operation for lung cancer smoke again as do 40% of heart attack patients.[329] Any suggestion that smokers smoke primarily for the 'taste and flavour' is rather undermined when it is considered that 40% of laryngectomy patients smoke again, some even learning to smoke through their stoma.[330] Smokers themselves seem well aware of the difficulty of quitting - according to the latest General Household Survey some 69% of all smokers would like to give up,[331] around one third try to quit each year, yet only about 2% of smokers quit successfully each year.[332] Some 15% of all smokers have their first cigarette within five minutes of waking.[333]

A Tobacco Regulatory Authority

188. A consistent theme of the evidence submitted to us from the tobacco companies was that Government no longer engaged in a meaningful dialogue with them; confrontation had superseded cooperation. According to the TMA, the trade body representing the tobacco companies operating

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[322] Q573.
[323] H E Jones *et al*, "Subjective and physiological effects of intravenous nicotine and cocaine in cigarette smoking cocaine abusers", *The Journal of Pharmacology and Experimental Therapeutics*, 1999:288, pp.188-97.
[324] *ibid*, p.196.
[325] *ibid*, p.196.
[326] Ev., p.570.
[327] Ev., p.570.
[328] Ev., p.578.
[329] Ev., p.63.
[330] Ev., p.488.
[331] *GHS 1998*, p.140
[332] *Nicotine Addiction in Britain*, p.186.
[333] *GHS*, p.142.

in the UK market, "There has been a marked reduction in the productive dialogue between the companies and Government, in particular in relation to the smoking and health issue".[334] Gallaher commented: "Regrettably, at the end of 1999 contact with Government is not as meaningful as it has been in the past ... a position Gallaher would like to see changed".[335] Imperial told us that it regretted the fact that "the constructive and effective relationship between the UK tobacco companies and the Government, which was epitomised by the consensual regulatory system created by the Voluntary Agreements, has broken down".[336] Mr Martyn Day, however, felt that the cooperative arrangements between the companies and the Government had benefited one side only: "I think that the whole approach of voluntary agreements ... was in the end one that worked in the tobacco companies' interests. It meant that they were always in negotiations and discussions. There is always that interplay which meant that the regulators became too familiar and were never keen to press too hard".[337] **We believe that the Government is right to keep its distance from the tobacco industry which has, in our view, been the main beneficiary of the regime of voluntary agreements.**

189. **The final conclusion of the RCP in its Report *Nicotine Addiction in Britain* was that "an independent expert committee should be established to examine the institutional options for nicotine regulation, and to report to the Secretary of State for Health on the appropriate future regulation of nicotine products and the management and prevention of nicotine addiction in Britain".[338] We concur. It seems to us entirely illogical that treatments for nicotine replacement therapy are subject to stringent regulation whereas the infinitely more deadly tobacco products they are designed to supersede escape any fundamental regulation. So we believe a Tobacco Regulatory Authority should be introduced.**

190. We have, throughout our report, indicated areas for which we think a Tobacco Regulatory Authority (TRA) could take responsibility. It could look at all aspects of the marketing of tobacco, the product itself and the nature of its health risks and developments in respect of 'safer' cigarettes. Smokers are addicted to nicotine in tobacco smoke. Yet the nicotine itself (contrary to what many smokers themselves believe) causes little harm.[339] It is the tar that accompanies the nicotine that does the damage. The companies themselves, in the 1960s, sought to isolate the carcinogens in tobacco, then gave up. We think that it is time that public health authorities addressed the issue of tobacco product safety. We think that those smokers who cannot quit are entitled to the safest possible product, and that no tobacco company can be trusted to give objective information on the safety of any of their products.

191. Consequently we would envisage the creation of a TRA with its own scientists, completely independent of the tobacco companies. When considering its function we should like to stress that we do not believe that the TRA could, for example, seek the elimination of nicotine from cigarettes. Its policies would have to recognize the realities of a global market for tobacco products, where any attempt to exclude nicotine - which would in our view be tantamount to prohibition of cigarettes, in that nicotine is, in the words of the RCP, the "unique selling point" of cigarettes - would be likely to be counter-productive. **The proposed TRA could, however, examine nicotine:tar ratios to determine how these could be optimised to minimise exposure to toxins.**

192. The TRA would, as we have stated, be the ideal objective judge of which additives and flavourings should or should not be permitted to be added to tobacco products, having as its test the overall impact on public health. **The TRA could consider the marketing of tobacco products, looking at areas of promotion going beyond advertising into issues such as point of sale displays.**

193. We would not expect the tobacco industry to welcome a regulatory authority with open arms - few industries would. We believe, however, that for too long the companies have enjoyed levels of commercial freedom entirely inconsistent with the fact that they produce what the Health Education Authority aptly called "by far the most dangerous consumer product on the market".[340] Given a clear steer by an appropriate regulatory authority, we believe that the tobacco companies could put some of their vast resources into devising alternative, safer nicotine delivery systems. For example, it has been suggested that tobacco deaths in Sweden have been reduced by the widespread use of a different

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[334] Ev., p.280.
[335] Ev., p.191.
[336] Ev., p.223.
[337] Q1229.
[338] *Nicotine Addiction in Britain*, p.189.
[339] Ev., p.16.
[340] Ev., p.18.

nicotine delivery system, moist oral snuff, *snus*, which seems to pose a much lower health risk than cigarettes. We share the CMO's grave doubts that there will ever be a safe cigarette and his distrust of 'safer' products. Further, the gap between product reform and epidemiological data is large, so mistakes could prove extremely costly. Nonetheless, **we do think that technological means to make cigarettes safer and less addictive should be explored and that a TRA could provide the necessary impetus for this. The TRA could, we believe, profitably set upper limits, and progressive reductions for known carcinogens.**

194. In a research capacity, the TRA could examine, and offer definitive statements, on the current scientific consensus as to the dangers of smoking, and could examine the most effective ways of persuading people to quit or never to start.

195. Assuming there is a will on the part of Government to tackle nicotine addiction in the very fundamental way that we propose, the question remains where should a TRA be located? One possibility would be for the UK to have its own TRA, in a way analogous to the Food Standards Agency or Medicines Control Agency; another would be for a TRA to be located in Europe, the source of much of what currently passes for tobacco regulation.

196. As we have noted, the Secretary of State told us that he favoured "an independent scientific committee" at a European level to monitor and assess information on products.[341] The EU option has many attractions, in terms of the wider scale of the benefits it could produce to the total European population and those countries receiving tobacco products sourced in Europe. But we are not convinced that a European TRA could be set up in the near future. Furthermore, although the current Health Commissioner greatly impressed us in terms of his commitment to reducing tobacco consumption, we believe that the current CAP subsidy of tobacco undermines any credibility of a European TRA.

197. Accordingly, **we recommend that the UK should institute a TRA with responsibility for all aspects of tobacco regulation consistent with the limitations posed by EU law. We would eventually like to see a Europe-wide TRA, but we feel that such a body would have no credibility until such time as the CAP subsidy for tobacco growing is eliminated.**

198. Turning to the question of how the TRA should operate we think it vital that such a body should be very well resourced to deal with the huge scientific and legal resources of the tobacco companies. We think that a proportion of tobacco duty should be hypothecated to finance the regulatory authority. In oral evidence the DoH told us that, to analyse and understand the technical composition of cigarettes, it relied on a scientific adviser, Professor Frank Fairweather, who worked one day a week, another scientific advisor working two days a week, and Mr Tim Baxter who worked full time. Mr Baxter explained that, as head of the Tobacco Research Unit, he had access to a technical advisory group via the Scientific Committee on Tobacco and Health.[342] Finally the DoH provided over £500,000 a year to the Laboratory of the Government Chemist to test tar and nicotine ratings.[343] Mr Baxter recognized there were many calls on the Department's resources, but he admitted that it would be "very nice" to have more resources since his team were "highly stretched".[344] When we put our concerns on this matter to the Secretary of State he agreed that the tobacco team in the Department was "quite small", but he contended that its work was supplemented by, for example, the professionals working in Health Action Zones and the Scientific Committee on Tobacco and Health. This latter body he described as "a very useful organisation".[345]

199. We would have more faith in the Secretary of State's assessment of the added benefit of SCOTH had that organization not been in abeyance for almost two years. **We regard the current staff resources devoted to tobacco control, especially in the area of scientific knowledge and advice, to be pitifully weak. Irrespective of whether the Secretary of State accepts our recommendation that root and branch reform is needed in terms of a TRA, we would expect to see a major increase in resources, met out of the enormous income the tobacco companies pay in duties to the Treasury.**

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[341] Q1320.
[342] QQ59-60.
[343] Q61.
[344] Q63.
[345] Q1265.

200. If UK staff resources are pitiful, those in the EU are utterly derisory. As the Secretary of State informed us, and as we saw for ourselves in Brussels, in Europe "there is just one official dealing with tobacco", Mr John Ryan.[346] In fact the situation is graver still, in that tobacco forms only one half of Mr Ryan's portfolio. We met Mr Ryan on our visit to Brussels and were extremely impressed by his knowledge and commitment. But we do not see how the Health Commissioner can deliver his objective of reducing tobacco consumption with such scant resources. **We recommend that the Secretary of State makes immediate and urgent representations in Brussels to create a far more substantial unit to combat the enormous resources of the tobacco industry. We believe that European policy is already hugely compromised by the CAP subsidy, and that unless appropriate resources go into tobacco control European action in this sphere will lack credibility.**

IV EXPANDING INTO NEW MARKETS

201. The main focus of the Committee's inquiry has been the health effects of smoking on consumers in the United Kingdom who buy their cigarettes through the legal channels provided by tobacco companies and legitimate retailers. However, during the course of the inquiry evidence was also taken concerning the alleged activities of the tobacco companies in seeking to expand their markets through two methods: by manipulating the market in smuggled tobacco goods, both in the United Kingdom and internationally; and by increasing cigarette consumption in the developing world. Both issues are complex and require further investigation. They raise issues outside the remit of this Committee; however, both activities lead to increased cigarette consumption, especially amongst groups of consumers who otherwise would not have access to cigarettes. The increased incidence of death and illness, domestically and internationally, caused by such consumption is of direct interest to us and is why we proceed to outline the evidence presented to us and our concerns.

Smuggling

202. BAT told us that 25 per cent or more of the tobacco products consumed in this country are smuggled into it.[347] Imperial's evidence stated that "Cross-border trading now comprises at least 80 per cent of handrolling tobaccos smoked in the UK, and at least 20 per cent of cigarettes".[348] As well as the millions of pounds worth of revenue lost to the Government, we were told that the tobacco companies were damaged by this trade, and that they thought it was caused by differential duty rates, with the United Kingdom having higher rates than France and other continental countries. Mr Wilson, of Gallaher told us: "I deplore smuggling and we will do whatever we can in order to bring it to an end. It is not in our interests; it is not in the interests of government; it is certainly not in the interests of the Department of Health. It is making more and more low price cigarettes available in this country. It provides no control over the access of children to cigarettes and it is a direct consequence of the enormous disparity of duty rates".[349] This approach was echoed by the representatives of Philip Morris, BAT, Imperial and R J Reynolds giving evidence alongside Mr Wilson.[350]

Andorra

203. It had been claimed that one route used to smuggle cigarettes into the United Kingdom was through Andorra. In March 1999, a *Sunday Times* article alleged that "Andorra.... is the hub of Europe's burgeoning smuggling trade ... with no tax, no VAT and almost no excise it is...a smuggler's paradise. Between 1993 and 1997, the number of British-made cigarettes sent to Andorra ... increased 117-fold. The tiny country imported 3.1 billion cigarettes in 1997 - equivalent to every Andorran smoking seven packets a day ... [Smugglers] operate by setting up front companies in the principality or in the neighbouring countries that buy cigarettes from British manufacturers, which are exempt from duty because of their destination. They are then legally exported from Britain, stored in warehouses in Andorra and then smuggled back to the United Kingdom".[351] HM Customs and Excise subsequently told the Home Affairs Committee that in 1996 cigarette exports from the United Kingdom to Andorra had risen very rapidly, but by late 1997 they had "tailed off just as

[346] Q1266.
[347] Q1376.
[348] Ev., p.223.
[349] Q1064.
[350] QQ1065-66.
[351] *Sunday Times*, 'Bootleg Britain', 7.3.99, p.12.

quickly", following work undertaken with the Andorran and Spanish authorities by the European Commission's anti-fraud organization.[352]

204. When it was put to Mr Wilson of Gallaher that his company's annual report had noted the increase in sales to Andorra and that he must have been aware that illegal smuggling had been occurring, he said that "of course" he was aware of that, but that he was "delighted when the authorities.... [stopped] it, but they stopped the smuggling, not us, as we were not doing anything illegal. I was very unhappy about it. I deplore smuggling." He also said that his company had helped the authorities' investigations.[353]

The Amber Leaf Briefing

205. Mr Wilson's robust stance against smuggling is to be welcomed, but it is undermined by the fact that the advertising agency employed on Gallaher's behalf was basing part of its strategy for one product - Amber Leaf hand rolling tobacco - on sales to bootleggers. The "Amber Leaf Briefing" prepared by M&C Saatchi and obtained by the Committee discusses "Trial through bootleggers" and describes "Adoption by bootleggers" as a key issue.[354] In oral evidence Mr Moray MacLennan of M&C Saatchi, told us that "Everyone is concerned about smuggling because it is the chief reason for more young smoking in the last two years".[355] He went on to say that the briefing document suggested that "what is being forced to happen in certain instances, because of the lack of control of smuggling in this country ... is that the tobacco companies, yes, are targeting legal distribution methods, some of which are on the continent. They sell it through legal distribution. Because of the lack of enforcement here in terms of smuggling, a lot of that finds its way back into this country through illegal distribution ... I think that really the onus is on the Government not the tobacco manufacturers".[356]

206. Mr Wilson told us that "The tragedy and the extraordinary thing about this whole situation is that we are here faced in the United Kingdom with the fact that four out of every five packets of hand rolling tobacco that are consumed in this country are sourced from outside this country. That is 80 per cent of the market sourced from outside the United Kingdom, predominantly Belgium and Holland. This is a direct consequence of the enormously high duty attaching to hand rolling tobacco here compared with Belgium. I think it is five times higher in this country than it is in Belgium. As a consequence, a pouch of hand rolling tobacco in this country which costs close to eight pounds will be available in Belgium for two pounds. That has led to a situation where 80 per cent of the market is sourced from outside this country and it leads to the ridiculous situation where the only way that you can develop distribution for a brand in this country is by making it available in Belgium".[357]

207. It seems that although Mr Wilson thinks it is a "tragedy" that hand rolling tobacco is smuggled into the country, his company works on the basis that it is prepared to sell to markets on the continent, aware of the knowledge that the goods will be smuggled back into this country; indeed not only are they aware, but their advertisers appear to deliberately frame their strategy to appeal to the criminals undertaking the smuggling. **Gallaher's stance that they deplore smuggling appears to be contradicted by their advertising which seems to want to court those doing the smuggling. Gallaher noted in its evidence to us that smuggled tobacco gives children access to tobacco. If they genuinely believe that this and the other problems associated with smuggled tobacco are a "tragedy", they should make sure that all their business practices and those of their advertisers work against the illegal trade rather than encourage it.**

Allegations regarding BAT and smuggling

208. During our inquiry serious allegations concerning BAT's involvement in international smuggling operations were made in the *Guardian* newspaper. While it was not claimed that BAT carried out the smuggling itself, it stated that "British American Tobacco condoned tax evasion and exploited the smuggling of billions of cigarettes in a global effort to boost sales and lure generations of new smokers".[358]

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[352] Home Affairs Committee, Minutes of Evidence, 25 May 1999, *The Work of HM Customs & Excise: Matters Relating to Crime*, HC478, QQ131- 32.
[353] QQ1059-1060.
[354] Ev. p.309.
[355] Q775.
[356] QQ776-77.
[357] Q1054.
[358] *The Guardian*, 31.1.2000, p.1.

209. The article was based on research undertaken by the International Consortium of Investigative Journalists, based in Washington DC. This research focused on the papers made public as a result of BAT's legal settlement of 1998, and which are now kept at BAT's depository in Guildford, which the Committee visited. The papers concerning smuggling are mainly from the early 1990s. The documents end in 1995. An additional memorandum received from ASH outlined the background to the smuggling claims, and gave examples of the original BAT documents on which the claims were founded. It stated that, against a "pitched battle" with Philip Morris for control of the worldwide cigarette market, evidence in the depository suggested that "manipulation and control of cigarette smuggling is an integral part of company business and expansion. The documents provide compelling evidence to suggest illegal trade is co-ordinated and promoted at the very highest level of the company".[359]

210. ASH's evidence further stated that a third of all internationally traded cigarettes (335 billion in 1996) are smuggled, thereby evading taxes and lowering the black market price. This stimulated demand, with knock-on health effects. They alleged that "cigarettes legitimately move through the 'in-transit' regime without bearing tax until they reach the final end market at which point tax is payable. Most smuggling involves the cigarettes moving out of the untaxed distribution chain and entering the final end market illegally - often through a third country. This can happen by legal export followed by illegal re-import or cigarettes in transit may be diverted from the legal to the illegal distribution chain".[360]

211. ASH claimed that while BAT's internal documents did not refer directly to smuggled goods, the following terms were used as euphemisms: *DNP* (Duty Not Paid); *Transit*; or *GT* (General Trade).[361] A background piece in the *Guardian*, also published on 31 January, quoted Lee Thompson, an RJR senior sales manager who pleaded guilty in 1999 to money-laundering charges, as saying that DNP is "an industry-wide term... It's essentially a long-winded term used by senior folks when they're talking around the topic of smuggling." Thompson was quoted as saying that "re-entry", "parallel market" and "transit" were similar euphemisms.[362] ASH's evidence quoted a number of BAT documents which it claimed showed the ways in which these euphemisms were used, for example:

– "In 1993, it is estimated that nearly 6% of the total world cigarette sales of 5.4 trillion were DNP sales ... A key issue for BAT is to ensure that the Group's system-wide objectives and performance are given the necessary priority through the active and effective management of such business".[363]

– "We will be consulting here on the ethical side of whether we should encourage or ignore the DNP segment. You know my view is that it is part of <u>your</u> market and to have it exploited by others is just not acceptable".[364]

– "I am advised by Souza Cruz [BAT subsidiary] that the BAT Industries Chairman has endorsed the approach that the Brazilian operating Group increase its share of the Argentinian market via DNP".[365]

The claims that the terms 'DNP' 'Transit' and 'GT' were euphemisms for smuggling were vigorously denied by BAT (see below, paragraph 219).

212. ASH also claimed that BAT engaged in 'umbrella operations' whereby a small trade in legitimate, duty paid exports could justify a large-scale marketing campaign to bolster sales in the much larger DNP sector. They claimed that the following extract provided evidence of such operations:

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[359] Ev., pp.429-30.
[360] Ev., pp.430-31.
[361] Ev., pp.431-32.
[362] *The Guardian*, 31.1.2000, p2.
[363] BAT Co Global Five-year Plan 1994-1998, quoted in Ev., p.433.
[364] Letter from Keith Dunt (now BAT's Finance Director), to 'Grant' [of Nobleza Piccardo, a BAT subsidiary], 24 June 1992, quoted in Ev., p.432.
[365] Memo from Keith Dunt to Ulrich Hester, Barry Bramley [Chairman, BAT Co Industries], Pilbeam, Castro, quoted in Ev., p.432.

– "It is recommended that BAT operate under "umbrella" operations. A small volume of Duty Paid exports would permit advertising and merchandising support in order to establish the brands for the medium/long term with the market being supplied initially primarily through the DNP channel".[366]

The author of the three documents quoted above, Keith Dunt, was at that time BAT's regional director for Latin America. He now sits on BAT's board as finance director.

213. ASH claimed that the evidence demonstrated that BAT did not merely acknowledge the existence of smuggled cigarettes, but that it deliberately stimulated the market, not just by 'umbrella operations', but by:

– treating smuggling routes as near-normal distribution channels;
– establishing relations with intermediaries that directly or indirectly supplied smugglers;
– controlling the price and supply of smuggled cigarettes;
– placing warehouses and marketing personnel near borders;
– organising complicated movements of goods to create difficulties in tracing the products;
– targeting routes with weak or corrupt official controls.[367]

214. Some of the most serious allegations made concerned Colombia. The *Guardian* reported that "BAT records show that billions of cigarettes were shipped from BAT subsidiaries in the US, Venezuela and Brazil to distributors in the free trade zone of Aruba, an island in the Caribbean just off the coast of Colombia".[368] It was claimed that they were then moved to Maicao or to Turbo - two special customs zones - and from there that they were smuggled into the country's black market. Two BAT subsidiaries supply Colombia - Souza Cruz and Cigarrera Bigott. A fax from Keith Dunt to Laux, of Cigarerra Bigott in April 1992 stated that "I do need to clearly understand the answers to the following:

– can we pursue the approach noted in your last strategy submission, ie continuing with DP and DNP in parallel and be seen as a clean and ethical company at the same time
– This "ethical correctness" would be achieved via letters to Government...etc - can we really do this and continue DNP...
A final point I must stress to you is that it is a key, key objective for you to achieve your company plan quoted total SOM [Share of Market] of 70.3%. This is an absolute focus for you."[369]

215. The *Guardian* stated that "in 1993 corporate records show that BAT subsidiaries imported a total of 3.98bn cigarettes into Colombia. However, 3.89bn of those cigarettes entered as duty not paid goods." However, it further stated that "since the mid 1990s legal imports of cigarettes have risen exponentially in Colombia. Official figures show that while only $4.6m in cigarette imports were registered in 1994, that number had leapt to $39.9m by November 1999. In August 1999 BAT signed a letter of commitment with the customs and tax department promising "....that if they have any evidence that distributors to whom they sell their products are, in turn, selling to smugglers, they will stop selling to those distributors." It also stated that "21 state governors and the mayor of Bogota have engaged American lawyers to prepare lawsuits in the US against British American Tobacco and Phillip Morris". It quoted Jose Manuel Arias Carrizosa, executive director of the federation of Colombian governors as saying that they were seeking "an indemnification for damages caused through contraband of cigarettes into the country ... We think there are two markets, one legitimate that pays its duties and taxes, and the other much bigger, illegal. That cannot be happening without the knowledge of the producing companies".[370]

216. The *Guardian* published a response to the allegations by Kenneth Clarke MP, BAT's deputy chairman, on 3 February. It stated that "BAT is a good corporate citizen which maintains high ethical standards. We reject allegations that we have 'condoned tax evasion and exploited smuggling'. We seek to work with governments around the world to find solutions to the problem of smuggling ... It is caused by high tax levels, different levels of tax on two sides of a border and the imposition of notional trade barriers to legal imports." It went on to state that "where governments are not prepared to address the underlying causes of the problem, businesses such as ours who are engaged in international trade are faced with a dilemma. If the demand for our brands is not met, consumers will either switch to our competitors' brands or there will be the kind of

[366] Note from Keith Dunt to Barry Bramley (BAT), 6 September 1992, quoted in Ev., p.436.
[367] Ev., p.429.
[368] *The Guardian*, 31.1.2000, p2.
[369] TB 18A, p.6, *not published.*
[370] *The Guardian*, 31.1.2000, p2.

dramatic growth in counterfeit products that we have recently seen in our Asian markets. Where any government is unwilling to act or their efforts are unsuccessful, we act, completely within the law, on the basis that our brands will be available alongside those of our competitors in the smuggled as well as the legitimate market". The article concluded by stating that "When governments and health campaigners are prepared to accept policies to reduce and control smuggling, we will always welcome such policies and co-operate with them".[371]

217. We thought that the allegations made against BAT were serious enough to merit further questioning of the company, and so we invited Mr Broughton and Mr Clarke to give evidence on its behalf, alongside ASH and Mr Duncan Campbell, one of the authors of the *Guardian* articles. Dismissing the general allegations about BAT's involvement with smuggling, Mr Broughton said that the documents cited demonstrated that BAT was aware that smuggling went on, but that it was not involved with that smuggling in the way suggested by ASH and Mr Campbell. He told the Committee that "an assumption seems to be being made by Mr Campbell that knowledge of what happens in a market is a criminal offence. I would say to you that we do understand pretty well what happens in various markets ... You would expect that of a consumer goods company like British American Tobacco. So knowing what happens in a market....and knowing [that there are] some smuggled goods in there is hardly a surprise ... Knowledge of what is happening in a market is not, as far as I have understood, a criminal offence".[372] Mr Broughton also made the point that in some markets the distribution chain was extremely complex, the inference being that it was difficult to trace the movement of goods from beginning to end of that chain.[373]

218. Mr Kenneth Clarke MP, the Deputy Chairman of British American Tobacco, supported Mr Broughton's assertion that, while it was widely known that smuggling occurred, no evidence had been produced which proved that BAT was the "originator, the organiser, [or] a participant in that smuggling". Indeed, he went on to say that BAT was "the victim of smuggling ... We seek to minimise smuggling".[374] Mr Clarke later said that "I satisfied myself that [BAT] is a company of integrity. It is an extremely good corporate citizen".[375]

219. Relating to terminology , Mr Broughton denied that terms such as 'DNP', 'general trade', or 'transit' were "specifically euphemisms for 'smuggled'. That is not to say that there are not times where DNP would be the same as smuggled in one market".[376] Mr Broughton said that to look at individual documents, or to quote small parts of individual documents was to risk taking them out of context.[377] Mr Clarke went further: he told the Committee that "any case which depends on taking sentences out of eight million pages ... is absurd".[378]

220. Given the severity of the charges made against them, and their robustness in denying them, the Committee asked whether BAT were intending to take legal action against the *Guardian*. Mr Clarke said that "we did not contemplate legal action, there has been no question of legal action"[379] and that to bring such action would give the investigative journalists involved credibility.[380]

221. Mr Bates of ASH said that the concerns raised merited an investigation into BAT's conduct by the Department of Trade and Industry (DTI). Asked whether he would welcome such an inquiry, Mr Broughton said he would not, but that the appropriate thing would be to have BAT's own audit committee, chaired by Mr Rupert Pennant-Rea, a non-executive director, to look into the allegations and to "review all of our current trading practices and ensure they are all entirely legal and that we are entirely comfortable with those practices and that there are no conspiracies going on between people within the company, the company, our distributors and other people".[381] Mr Bates subsequently called this an "important and welcome development".[382]

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[371] *The Guardian*, 3.2.2000, p.12.
[372] Q1361.
[373] Q1361.
[374] Q1369.
[375] Q1384.
[376] Q1361.
[377] Q1387.
[378] Q1400.
[379] Q1367.
[380] Q1372.
[381] Q1509.
[382] Ev., p.483.

222. The allegations made against BAT in regard to smuggling are extremely serious and merit careful investigation. This Committee is not the appropriate body to conduct such investigations and would be going beyond its remit were it to do so. **We welcome the fact that BAT's audit committee will look into this matter and we will be calling for its findings when they are available. But this is not enough. The allegations need to be looked at independently and we therefore call on the DTI to investigate them. If they prove to be substantiated, the case for criminal proceedings against BAT should be considered; if they prove to be false, then those perpetrating them should publicly apologise to BAT for what will have amounted to a malicious slur on the company's name.**

Expanding markets in developing countries

223. The Government's tobacco White Paper notes that there are over a billion smokers across the world, with nearly one third of those in China. It states that worldwide deaths from smoking - currently standing at 3 million annually - will rise to 10 million in about 30 years' time. It further notes that "smoking is fast increasing in third world countries and in Eastern Europe ... Many of the countries in which smoking is increasing fast have limited regulation of tobacco or health education and health care systems which are ill-equipped to handle the consequences. In parts of Africa tobacco companies are using advertising and marketing campaigns, sponsorship of events and price wars to promote cut-priced cigarettes".[383]

224. The World Health Organisation (WHO) told us that "we cannot simply stand by and count the dead. Internationally, the WHO is taking the lead in the United Nations in heading the development of the Framework Convention on Tobacco Control. The Convention would address transnational aspects of tobacco control",[384] although the WHO makes it clear that there will still be a need for national and regional action. Dr Derek Yach told us that while the incidence of smoking in western countries was declining, smoking prevalence was rapidly increasing elsewhere. He said that over the past 20 years there had been a decline of "about 1.6 per cent of adult consumption per capita per year - compared to increases ... of 8 per cent per year for 20 years in China, 6.8 per cent in Indonesia, almost 5 per cent in Syria ... By the 2020s we estimate that there will be around 10 million deaths [caused by smoking] and 70 per cent of those will occur in developing countries ...which means we are going to face one of the largest, if not the largest, public health challenges in the 2020s and 2030s ... This eclipses the sum total of deaths from malaria and tuberculosis and many other causes of deaths worldwide".[385]

225. The Framework Convention on Tobacco Control mentioned by Dr Yach is a new legal instrument that will circumscribe the global spread of tobacco and tobacco products. The Framework Convention will establish legal parameters; separate protocols will make up the substantive part of the agreement. It is expected that the Convention and possible related protocols should be adopted by the World Health Assembly no later than May 2003. The Government has welcomed the Framework Convention and its White Paper states that "we will do everything we can to help, drawing on our experience of tackling tobacco, and will be discussing with the WHO how we can most effectively be involved in this landmark initiative".[386]

226. Given the huge scale of the problem, it is alarming to note the reaction of some tobacco companies to the WHO's actions. Mr Broughton of BAT told his company's AGM on 29 April 1999 that "driven by the western agenda, [WHO's] priorities are different from those of health ministers in the developing world, for whom issues like malnutrition, lack of sanitation, infant mortality and AIDS loom much larger ... Regrettably, the WHO has got the smoking issue completely out of proportion with its Tobacco Free Initiative ... Indeed the WHO seems to have been hijacked by zealots in its desire to set itself up as some sort of 'super-nanny'."[387] This approach seems to belie the claim made in BAT's written evidence to the Committee that it seeks "to co-operate with the Government and public health authorities to the fullest extent reasonably possible. The reason for this is simple. We take the view that the most effective way of developing rational smoking and health policies is for the industry, the Government and public health bodies to work with each other and to engage in a free and frank exchange of views".[388]

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[383] *Smoking Kills,* p.75.
[384] Ev., p.97.
[385] Q283.
[386] *Smoking Kills,* p.79.
[387] Speech by Mr Broughton at the BAT Annual General Meeting on 29 April 1999 (TB 28G, *not published*).
[388] Ev., p.130.

227. The idea that developing countries were uninterested in tobacco control was rebutted by Dr Yach. He said that the WHO represented the will of its 192 member states and that "there is virtually no other area of public health where there has been so much international consensus." He went on to state that, although it was sometimes said that African ministers accorded tobacco control a low priority, at a conference of African health ministers held in October 1999, a range of tobacco control options were discussed and that "in their discussions on tobacco they acknowledged the need for action on all the areas being discussed in western countries ... This was a relatively short meeting with a massive public health agenda. They selected to highlight the importance of tobacco as a public health problem because they know that somewhere down the line they are going to face the problem and addressing it early and vigorously is going to save enormous public resources. The truth is that wherever we go there is not a single country where increasingly the ministries of health and the ministries of finance are not beginning to recognise that tobacco control makes sound public health sense and sound economic sense".[389]

228. Mr Broughton's comments were further undermined by Zhang Wenkang, Minister for Public Health, People's Republic of China, who stated in correspondence to the Committee that "The Ministry of Health of China has recognized that the effect of tobacco on health is an important public health issue. In order to protect the health of the public, Chinese governments at all levels have been actively facilitating the tobacco control programme in the last twenty years ... We think that tobacco control ... [requires the] joint efforts of all countries in the world. Therefore, we support the Framework Convention on Tobacco Control of the World Health Organisation".[390]

229. There are also concerns that the tobacco industry's negative attitude towards the WHO's tobacco control objectives might go beyond words to deeds. Dr Yach quoted a senior Philip Morris official speaking at a Philip Morris sponsored conference in 1988, where there were also representatives from other tobacco companies, as saying that the WHO "'has an extraordinary influence on government and consumers and we must find a way to defuse this and reorientate the activities to their prescribed mandate'". Dr Yach also said that a document emerging from the conference "discussed 'countermeasures designed to contain, neutralise, reorientate ... WHO' and stated 'the necessary resources should be allocated to stop WHO in their tracks'".[391] Such was the level of concern felt by the WHO at the activities of the tobacco industry, that it established an inquiry into "the way in which WHO and the UN systems have had their policies thwarted by the industry ... This is unprecedented ..." The World Bank has also joined the inquiry and has nominated a top anti-corruption expert to assist the inquiry.[392]

230. **We welcome the Framework Convention proposed by the World Health Organisation and the Government's support for it. However, any success will be dependent on a responsible approach being taken by the tobacco companies. Depressingly, there is little sign of that in the cheap jibes made at the WHO's expense by BAT. To call an organisation committed to improving global health 'zealots' and a 'super-nanny' because of its concern about the 10 million deaths which will be caused by tobacco each year by the late 2020s seems to us bizarre. We hope that the other companies - and, belatedly, BAT - will work constructively with the WHO. On a national level, we recommend that the Government requires the British tobacco companies to provide an annual summary of the action they have taken to co-operate with the WHO, to which the WHO should be invited to respond. If the action taken by the companies is not satisfactory, further action, including legislative and fiscal approaches, should be considered. It would be a hollow victory if, as a result of more stringent action taken on tobacco control in the developed world, smoking related deaths were merely exported to the world's poorer nations.**

V THE TOBACCO ARCHIVES

231. As a consequence of court orders following the Minnesota Tobacco Trial, and the disclosure of documents following investigations conducted by the US Food and Drug Administration and Federal Trade Commission, around 35 million pages of internal tobacco company documents from the major US tobacco companies have recently been disclosed. As a consequence of the terms of the settlement between the State of Minnesota, Blue Cross and Blue Shield of Minnesota and nine

[389] Q286.
[390] Amongst the measures adopted by the Chinese Government are: bans and restrictions on advertising; restrictions on smoking in public places; and a Tobacco Free Schools initiative. See Ev., p.631.
[391] Q269.
[392] Q269.

tobacco industry organisations agreed in August 1995 the tobacco companies, including BAT, were obliged to place material in the public domain.[393] Material from the US companies is stored in a depository in Minneapolis; the papers from both Philip Morris and R J Reynolds, from whom we took oral evidence, are stored there and are also accessible on the internet.

232. The significance of the disclosure of this huge body of material cannot be over-estimated. Dr Yach of the WHO told us that the documents allowed them to "walk through the minds of the tobacco industry". The documents, he believed, performed the same function as knowledge of the mosquito would give a researcher into malaria.[394]

BAT

233. Under the Consent Judgement settling the Minnesota proceedings, British American Tobacco Limited was required to maintain and operate a depository at Guildford.[395] BAT Industries plc and British-American Tobacco Company Limited were only joined in the litigation in the USA at a late stage.[396] As a consequence of this factor they were only able to comply with the timetable set out in the Minnesota action by stocking the Guildford Depository with all "potentially relevant files" rather than selecting and indexing individual relevant documents. The terms of the agreement also excluded public access to "privileged documents and Category II trade secret documents (relating to blends and formulae)".[397] The order stipulated that BAT should make the depository accessible to the US plaintiffs and their lawyers and should be open to the public for a period of 10 years from February 1998. The Guildford Depository finally opened to the public in February 1999. In the interim, lawyers to the plaintiffs had access to the documents and had requested copies of 350,000 pages many of which they have subsequently placed on the internet.

234. We wanted to explore the extent to which BAT had actually facilitated public access to the Guildford Depository. Following our visit there, and having assessed a number of oral and written submissions, we found a number of areas in which BAT had placed obstacles in the way of researchers and potential litigants examining material in the Guildford Depository and denied what we would consider to be reasonable access. Whilst the Depository was open from 8am to 8pm for the lawyers and plaintiffs, the opening hours to the public are restricted to 10am to 4pm: the Minneapolis Depository is open from 8am to 8pm.[398] Since the Depository opened to the public, BAT has restricted access to "one organization at a time" apparently because of the strain imposed on its resources by the number of requests for copies.[399] From this single organization a maximum of six visitors are permitted.[400] Ms Judith Watt, the former Executive Director of the Victoria Smoking and Health Program in Australia, told us that access to the Depository "has grown significantly more difficult as time has gone by".[401] She forwarded to us correspondence indicating a number of delays and misunderstandings in granting her and her co-researchers reasonable access.

235. BAT argued that the Depository had only been visited on 133 of the 220 days it had been open and that "only one British organization has visited". They suggested that "none of the visitors has been an academic who might have a research interest".[402] In oral evidence Mr Broughton commented that they had not had "one single scientist" visiting.[403] Establishing the reliability of this statement might, however, prove difficult since, according to Ms Watt, the Visitors' Book has now been removed.[404]

236. We find it a matter of concern that BAT takes such an interest in those organizations using the Depository. We do not think it is appropriate for them to sift through the individuals wishing to examine public access materials, working out who is a scientist, who is an academic, who is British or who is a potential litigant. Their limit of a single organization per day, imposed apparently

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[393] The defendants were Philip Morris Incorporated, R J Reynolds Tobacco Company, Brown and Williamson Tobacco Corporation, BAT Industries plc, Lorillard Tobacco Company, the American Tobacco Company, Liggett Group Inc, the Council for Tobacco Research and the Tobacco Institute. See Michael Ciresi *et al*, "Decades of Deceit: Document Discovery in the Minnesota Tobacco Litigation", *William Mitchell Law Review,* 1999:477 pp.477-566.

[394] Q260.

[395] Ev., p.338.

[396] Ev., p.337.

[397] Ev., p.338.

[398] Ev., p.524.

[399] Ev., pp.524-25.

[400] Ev., p.351.

[401] Ev., p.525.

[402] Ev., p.337.

[403] Q938.

[404] Ev., p.636.

because of the strain on resources caused by multiple group visits, seems to us entirely unreasonable. BAT is a wealthy company with large resources well capable of using them to facilitate greater access to the Guildford papers. The true nature of the priority it attaches to the Guildford site can perhaps be gauged from the fact that the Chairman of BAT told us he had "never actually been taken round the depository". [405]

237. We asked a professional archivist, Dr Caroline Shenton, formerly Senior Archivist at the Public Record Office, to accompany us to the Guildford Depository and at our request she submitted a report on her findings. This was extremely critical of the current arrangements and proposed a number of reforms which we hope BAT will act on. She told us "there is no archival reason why 12 reading room places could not be provided for 12 different visitors" and that "the constraints imposed on the number of visitors allowed to book into the Depository on a single day relate to the amount of staff and equipment BAT employs at the Depository in order to retrieve documents, and not to any issues of handling and preserving the documents".[406] She also noted that none of the nine staff employed at Guildford were trained in archives, and found it "surprising" that the records manager was unqualified.[407]

238. We examined for ourselves the indexes to the files and found that these gave no useful indication of the material contained in the eight million pages stored at Guildford. For example, a search for "disease" yielded only sixty nine entries. This was because only the title of the file was indexed and, as we discovered, this often gave absolutely no indication of the contents.[408] As Dr Bill O'Neill, Scientific Advisor to the BMA, put it: "What does one do when faced with a warehouse of documents that are not adequately indexed?"[409] Dr Shenton suggested that it would be helpful if the index, such as it was, could be made available on the internet. In her view this would "require relatively little time or money".[410] The issue of making documents available on the internet was one we pursued with Mr Broughton. He felt that putting on the internet the remaining "seven and three-quarter million pieces of paper would be an extreme effort for absolutely no purpose whatsoever". Nevertheless, he promised to look at our recommendations in this area.[411]

239. When we visited Guildford, we learned that all pages of documents which were requested for photocopy were first scanned by BAT and sent to their legal department to check for privileged or trade secret information. Once approved, a paper copy is forwarded to the person requesting copies.[412] Dr Shenton noted that there was, therefore, "a growing corpus of checked scanned images (or possibly electronic text if the scanning has been performed by optical character recognition) available within BAT which could be made available online".[413]

240. We believe that the balance of evidence suggests that BAT currently attaches no priority to facilitating public access to material held in Guildford. Dr Yach of the WHO suggested that, for the sum of $2-4 million, BAT could scan all its documents and put them on the internet. This is the course of action some of the American companies have taken, sometimes on cost grounds, in that placing material on the internet reduces the staff time required making it available in photocopied form.[414]

241. **We believe that a commitment on the part of BAT to put all non-privileged documents held at Guildford on the internet, preferably in a searchable form, would indicate that it was serious in its attempts to "start the new millennium with a positive approach" to bringing an end to the allegations and arguments which have characterised relationships between public health authorities and the tobacco companies.[415] At the very least, we believe BAT should automatically put all non-privileged documents which it has already scanned, or which it scans in the future, on the internet. Should BAT find this simple, and relatively cheap, option beyond it, the obvious inference should be drawn that they are resisting any attempts to have wider public access to this material. We regard BAT's limits of one organization, and a maximum of six visitors, per day to be indefensible. It seems to us that BAT is failing to enter into the**

[405] Q964.
[406] Ev., p.542.
[407] Ev., p.543.
[408] Q936.
[409] Q314.
[410] Ev., p.543.
[411] Q942.
[412] Ev., p.543.
[413] Ev., p.543.
[414] Q3268.
[415] Q388.

spirit of the Minnesota agreement. Finally, we think that BAT should employ professionally qualified staff and up to date computers at Guildford - in this respect the contrast between the company's research and development facilities, with their highly qualified staff and state of the art equipment which we saw at Southampton, and the archive, with its untrained staff and slow computers, was stark.

Gallaher and Imperial

242. We also wanted to explore the willingness of the major UK companies to place its archive material relating to the companies' knowledge of the health risks of smoking in the public domain. We asked both Mr Peter Wilson of Gallaher and Mr Gareth Davis of Imperial, what the attitude of their companies would be to such a request. Both companies have been obliged in the recent past to make available substantial quantities of internal documents under the discovery process as part of the recent failed UK class action against the companies and both have millions of pages of material in CD-ROM form.

243. Mr Wilson of Gallaher promised the Committee that he would explore the possibility of making this documentation available on the internet.[416] In a subsequent written memorandum he indicated that Gallaher had agreed to put this material in the public domain and would be placing the health related documents on its company website. **We very much welcome the approach that Gallaher has taken to our request that it should make its archival material on the health risks of smoking publicly accessible. We believe that this represents a more mature response to the public health issues than has been evinced by UK companies in the past and that Gallaher should be commended for its responsible approach in this area.**

244. In contrast to the openness of Gallaher came the much more disappointing response of Imperial. During our hearings Mr Gareth Davis promised to look at the possibility of making electronically available the equivalent documents for Imperial. But in the end Imperial has not complied with our wishes that such material should be freely available in the public domain. Correspondence with Imperial's lawyers indicated that they would only release material for the purposes of the Committee's own research. Given the fact that the material they produced was indexed in a fairly meaningless way, that the text was not searchable, and that the documents concerned ran to hundreds of thousands of pages this offer was, effectively, worthless. Imperial submitted a file index of all their documents, and suggested that the Committee might select particular documents for examination. Again, these files were not indexed in any useful way. For example, files were listed by the name of the recipient and sender rather than by subject matter.

245. In the end, Mr Gareth Davis's promise to co-operate with the Committee in what ways he could proved worthless. **We believe that Imperial have adopted a reactionary and defensive posture. Their refusal to place in the public domain documents which may have a real bearing on the public health community's knowledge of the health risks of smoking seems to us lamentable.** According to Mr Martyn Day, who did at one time have access to all the documentation, Imperial at one stage adopted an even more unhelpful approach:

> "one of the rather disturbing things is that somebody who came into Imperial in the late 1980s destroyed a lot of documents, had a big fire, so there may be a lot of fire dust on the documents ...."[417]

246. We agree with Mr Day that it would be "to everybody's advantage" if all the UK tobacco documents came into the open.[418] It has been a consistent theme of our report that for too long the UK tobacco companies have operated in a totally artificial environment, where they have been able to deny the truth about the health risks of smoking while Government has failed to take responsibility to regulate the product. It might be felt in some quarters that it was now too late to take regulatory issues seriously. After all, the tobacco companies themselves make much of the fact that smokers have received a mass of information, both from public health bodies and the media, to the effect that smoking is an extremely dangerous activity. From this they conclude that smokers who persist in smoking are making an informed choice.

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[416] QQ905-907; QQ924-27.
[417] Q1239.
[418] Q1225.

247. Laying aside the arguments we have put forward that smoking is an addiction normally entered into in childhood before an adult choice can be made, we believe it is important to consider who is actually likely to die from tobacco today and where the epidemic of tobacco deaths will strike most hard in the future. In the West, as evidence we have cited earlier suggests, nicotine addiction is increasingly the preserve of the poor and least educated. In the future, as rates fall in the West, it is to the developing world that the companies are turning. There it would appear they will find a more congenial environment, with populations less well informed of the risks, public health authorities less well armed to counter these, and few restraints on the marketing, sale and composition of tobacco products. Far from dying out, the practice of smoking is actually fast-growing. Whilst one in three adults worldwide currently smoke (about 1.1 billion) that figure is predicted to rise to 1.6 billion by 2025.[419] According to the World Bank, some 80% of these live in the low and middle income countries. The figures of 60 million deaths worldwide since 1950 will be dwarfed by the figures for the next 50 years if current trends continue and ten million people die each year by 2030. The fact that, in terms of total mortality, the tobacco epidemic has hardly begun makes strong and effective counter measures on the part of public health authorities, in our view, a moral necessity.

[419] *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1999, p.13.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

(a) **We very much welcome the Government's firm commitment to action to combat smoking in its White Paper *Smoking Kills*. We do not, however, regard the targets they have set as sufficiently challenging to justify the Department of Health's rhetoric that it is for the first time tackling smoking seriously. The target trends for adult smoking are no more than would be expected extrapolating from the general trends since the 1970s. We believe that the DoH should set much tougher targets and take such measures as are open to it to achieve those targets (paragraph 19).**

(b) **The Royal College of Physcians (RCP) drew the following main conclusion: "Cigarette smoking should be understood as a manifestation of nicotine addiction ... the extent to which smokers are addicted to nicotine is comparable with addiction to 'hard' drugs such as heroin and cocaine." We endorse this conclusion, which underlies many of the recommendations in our report and is, we believe, of fundamental importance to policy makers in the UK and elsewhere (paragraph 33).**

(c) **Bearing in mind that asthma causes 1,400 death per year, we do not regard asthma attacks as merely unpleasant and believe that policy goals related to Environmental Tobacco Smoke must take account of the real health risks it poses (paragraph 42).**

(d) **We find it inherently unsatisfactory that the trade association of the tobacco companies was unable to comment on the research activities of its predecessor body. It seems to us that this is symptomatic of a more general failure by the industry as a whole to take responsibility for the effect of its activities (paragraph 52). We also find extremely unconvincing the explanation that the Harrogate research stopped simply because analytical techniques improved to such an extent that researchers were able to analyse ever-smaller components (paragraph 53).**

(e) **Tobacco companies are commercial enterprises whose imperatives have nothing in common with the public health community. Their past records of denial and obfuscation militate against any claims they may make towards scientific objectivity. We find ourselves most strongly agreeing with the viewpoint expressed by Dr Axel Gietz, Vice President of R J Reynolds Tobacco (UK) Limited: "we are aware that we do produce and market a very controversial product ... what we do in terms of product development ... is much more important than anything we say". We believe it is for public health authorities to measure the risks of smoking and to set appropriate regulatory parameters (paragraph 55).**

(f) **The current regulation applying to tobacco products is entirely inadequate (paragraph 59). We take the view that if the Government fails to take the sort of direct regulatory action we recommend below as a consequence of its anxiety not to be seen to be 'nannying', it would be failing in its responsibilities (paragraph 61).**

(g) **We believe that the Department should urgently commission comprehensive research relating to the age at which children start smoking, the reasons they begin, continue and quit smoking, the relationship between pack size and consumption by children, and the sources from which children obtain cigarettes. We believe that the Tobacco Regulatory Authority we propose below at paragraph 189 would be the appropriate body to commission and analyse such research (paragraph 63).**

(h) **We believe that a much more widespread use of proof of age cards would reduce the incidence of retailers unwittingly selling tobacco products to children. We think it would be helpful if the Government could approve those photo-identity proof of age cards it regards as reliable and useful. Such cards could then bear an appropriate marking to indicate that they belonged to a Government approved scheme (paragraph 70).**

(i) **Detection of those illegally selling tobacco to youngsters is the job of trading standards officers, and we believe they need to be given clear instructions, definite targets and dedicated resources. They should also be made accountable for the success of their operations and ensuring shopkeeper compliance (paragraph 71).**

(j) **We believe it is deplorable that so many local authorities have failed in their responsibilities to deter under age tobacco sales. Those not undertaking regular enforcement procedures should be named and shamed (paragraph 72).**

(k) **We regret the fact that the Scottish Office has not modified its guidance [on the use of children in test purchase cases], and call on the Secretary of State to make appropriate representations to achieve a uniformity of approach towards tackling sales of tobacco products to children (paragraph 73).**

(l) **The policy failure on youth access to tobacco results from both inadvertent and deliberate law breaking. This was recognized in the White Paper, which promised to draw up an enforcement protocol with local authorities to tackle both issues. We welcome this - the terms of the Children and Young Persons (Protection from Tobacco) Act need to be greatly strengthened - but we feel that the protocol will need to be strongly worded, and backed by both adequate resources and severe penalties for non-compliance, if it is to have any effect. We also note that, despite "lengthy discussions" having taken place, no such protocol has yet been agreed. With this in mind, it is our view that Government cannot simply shift the blame for lack of enforcement on to local authorities, trading standards officers and magistrates. It is essential that the Government issues clear guidelines and quickly develops effective protocols to ensure more test purchases take place and more convictions are secured. (Paragraph 74).**

(m) **We recommend that magistrates should be actively encouraged to pass deterrent sentences by means of guidance from central Government (paragraph 75).**

(n) **One possible way to enhance deterrence, would be to introduce a system of 'negative licensing'. Rather than requiring all retailers to be licensed, this would simply forbid sale by those who have infringed the law. We believe that this would act as a potentially powerful deterrent. It would also be appealingly appropriate in that the punishment would fit the crime – "shopkeepers who sell to children can't be trusted to retail tobacco responsibly, therefore should not be permitted to do it at all". Such a system would also, we believe, act as an incentive for retailers and those aged 16 and over to involve themselves in proof of age schemes. However, perhaps the most attractive feature of negative licensing is that it would not require a new or extensive bureaucracy to support it. Existing local licensing boards could implement it as and when convictions occur. Alternatively, the Department might wish to assess the advantages of introducing a comprehensive licensing system for *all* retailers of tobacco, which would give consistency with the arrangements for the sale of alcohol (paragraph 76).**

(o) **We believe that the measures set out in this and the previous section will bring about significant reductions in the numbers taking up smoking. The tobacco industry's public stance on children's smoking is explicit: they see tobacco use as an adult activity, do not endorse underage sales and, and in some cases support an increase of the legal age to 18. On the other hand, as noted above, most smokers start as children and complete prevention of child access to the product would have serious repercussions for their profits. The companies' response to the proposals made here will help establish where their priorities really lie (paragraph 77).**

(p) **The evidence we have reviewed from the advertising agencies leads us to conclude that, once more, voluntary agreements have served the industry well and the public badly. Regulations have been seen as hurdles to be overcome or side-stepped; legislation banning advertising as a challenge, a policy to be systematically undermined by whatever means possible. We recommend that any future regulation of marketing should be statutory, and overseen by an independent and powerful regulatory body which has the consumer's interest at heart, such as the Tobacco Regulatory Authority which we propose below at paragraph 189 (paragraph 88).**

(q) **Most of the tobacco companies have sought to challenge the Government's commitment to introduce an advertising ban in advance of the date for implementation set by the EU directive. The argument they have repeatedly advanced is that tobacco advertising does not increase consumption, it merely persuades smokers to switch brands. However, looking through the documents that the agencies themselves produced, this view is completely discredited (paragraph 89).**

(r) **Our review of the copious evidence from the advertising agencies, which includes substantial quantities of market research, leads us to conclude that the advertising agencies have connived in promoting tobacco consumption, have shamelessly exploited smoking as an aspirational pursuit in ways which inevitably make it attractive to children, and have attempted to use their creative talents to undermine Government policy and evade regulation. We welcome the Government's commitment to end all forms of tobacco advertising and sponsorship (paragraph 99).**

(s) **In our view, such connotations [associations between smoking and the 'glamour' of Formula 1 in the advertising papers we examined] blatantly subvert the attempts of successive Governments to dissociate smoking from aspiration and glamour. They also expose as pusillanimous the decision of the present Government to agree to the exemption for Formula One from the EU Directive banning advertising and sponsorship until 2006 (paragraph 102).**

(t) **We share Mr Mosley's view that the EU's tobacco subsidy undermines its anti-tobacco health promotion strategy, a point we touch on elsewhere. We also regard it as unacceptable that the majority of health ministers [in each of the countries where Grand Prix are held] questioned have not had the courtesy to reply to an invitation to contribute on a crucial health issue put to them by a major sporting body [the FIA]. We recommend that the Department of Health writes to each its counterparts in those countries which have and have not replied, to ascertain the nature of the replies given and the factors underlying the failure to reply by 10 governments. We would like to be provided with copies of this correspondence (paragraph 106).**

(u) **We see no reason why sponsorship has been treated more leniently than advertising in the White Paper, and we call on the Government to remove tobacco sponsorship in general, and that pertaining to Formula One in particular, as soon as is legally possible. If more evidence is needed to support this move, Formula One Management's offer, in response to an inquiry we made, to fund independent research should be accepted and supervised by the Tobacco Regulatory Authority which we propose below (paragraph 108).**

(v) **We believe that the extraordinarily dangerous nature of the product being marketed means that tobacco companies cannot expect to operate in the same commercial environment as most other industries. We are concerned that tobacco manufacturers continue to think of cigarette packs as being a way either of exploiting the aspirational nature of their products or conveying implied health messages. Notwithstanding the potential restrictions caused by EU single market legislation we believe that the advantages and disadvantages of introducing generic or plain packaging for all tobacco products should be carefully assessed by the Tobacco Regulatory Authority we propose below (paragraph 189). Such packaging would be of a standard colour with the brand name in a standard type face. Beyond this, the only other permitted information would be health warnings and consumer information about product contents (paragraph 112).**

(w) **Other promotional techniques, such as direct marketing, point of sale displays, brand stretching (the branding of non-tobacco products such as clothing with tobacco marques) have also received less attention than advertising. We believe that the proposed Tobacco Regulatory Authority (see below) should monitor these activities, check compliance with current controls and propose new ones whenever there is a danger that a particular activity will encourage consumption. Innovative promotional efforts are also a threat, especially on the internet, and will, we believe, require careful monitoring (paragraph 113).**

(x) **Most fundamental of all, every effort needs to be made by both the Government and the tobacco companies to limit the appeal of tobacco brands to young and new smokers. As a start, we believe the Government should compile and publish information on those brands that have particular appeal amongst children. Such data could inform the operation of the proposed Tobacco Regulatory Authority, both in terms of its analysis of any ongoing marketing activity and its assessment of additives (paragraph 114).**

(y) **In our view, voluntary agreement on passive smoking cannot yet be said to be really delivering smoke-free environments to all those who want them. The very real improvements of recent years probably owe more to market forces than to any action by Government. Indeed, we believe that market forces will continue to be a significant driver for change in this area. On balance, we accept that in the leisure sector, voluntary codes may offer the best way forward. We would hope, however, that these yield much more effective action on the part of the hospitality sector than has been the case to date. In this respect, we believe it is essential that the Government sets out a strict timetable for the targets to measure performance cited in its White Paper. Certainly, if the latest agreements do not significantly improve the situation we think the Government will have to consider what more stringent actions it could take. In respect of the workplace, we believe that the proposed Health and Safety Commission Code of Practice offers a good way forward (paragraph 121).**

(z) **We believe that even greater efforts need to be made throughout the primary care teams to educate adults on the dangers their smoking poses to children (paragraph 121).**

(aa) **We believe that a tobacco regulatory authority such as that we propose below in paragraph 189, with access to high quality scientific advice, would be the appropriate body to advise the Government on the evidence as to the health risks of passive smoking, possible measures to reduce its impact and even the potential benefits of innovative products which might reduce the amount of sidestream smoke which cigarettes emit (paragraph 123).**

(bb) **Tobacco companies should produce the least harmful product possible. We are totally unconvinced that Imperial Tobacco can be committed to producing such a product while its public stance is to refuse to accept that cigarettes are intrinsically unsafe (paragraph 125).**

(cc) **Three charges are made against the tar reduction strategy. The first - that, mainly because of compensatory smoking, it is simply ineffective in making cigarettes less harmful - is disputed amongst experts. Although the evidence about compensatory smoking is convincing, it is difficult to reconcile this with the fact that deaths from smoking have fallen faster than can otherwise be accounted for during the period in which the policy was enacted. This latter point leads us to support the further reduction in tar levels in the proposed EU Directive and the further provisions made in the Directive to review the effectiveness of the tar reduction programme based on the best evidence available. We further recommend that the Tobacco Regulatory Authority which we want to see established should, as a high priority, examine the factors responsible for the reductions in death rates from smoking, with a view to establishing a firmer basis for regulating cigarettes in the future (paragraph 137).**

(dd) **The two further charges are that actual or implied claims about beneficial health effects of low-tar cigarettes have lessened the incentive of people to give up smoking entirely; and that it has distracted from the other, potentially much more effective, regulatory options available. We take these two charges very seriously. In order to tackle the first, we recommend that the terms 'light', 'mild' 'ultra', 'low tar' and 'low nicotine' be proscribed by law in cigarette branding and marketing (by EU Directive, or by primary legislation in the United Kingdom). To tackle the second charge we recommend that the Tobacco Regulatory Authority which we propose at paragraph 189 be able to examine, propose and enforce innovative and effective alternative regulatory regimes. It is clear that a regulatory approach based on reducing nominal tar yields alone is inadequate (paragraph 138).**

(ee) **Given that, because of their addiction, people will demand cigarettes for the foreseeable future, it is clearly preferable that they smoke 'safer' cigarettes. We therefore hope that such products will be developed. We note the argument put forward by some of the companies that the successful marketing of such products is stymied by the regulatory framework. We recommend that the new Tobacco Regulatory Authority which we want to see established should have powers to review and approve applications from companies to market such products in a way which conveys their potential benefits compared to normal cigarettes, as long as full information about the product is provided and assessed by an independent panel of experts (appointed by the Authority), a process which should be funded - via a charge by the Authority - by the company applying. There should then be regular and rigorous reviews of the product and its effects to ensure that it deserves to retain its preferential marketing status. We would expect that status to be very narrowly defined and its promulgation strictly enforced by the Authority (paragraph 146).**

(ff) **We believe responsibility for licensing additives permitted for use in tobacco products sold in the UK should be passed to the Tobacco Regulatory Authority we propose below. We further believe that this body should take account of the overall public health impact of the inclusion of an additive in determining whether or not it should be permitted for use in tobacco products (paragraph 154).**

(gg) **We think that the position of the tobacco companies in withholding information on the additives their cigarettes contain is completely untenable. Consumers have a right to know what they are smoking, including the percentage of the product such additives form, and we believe that this information should be available on every packet. We believe the companies should immediately take steps to ensure this is done and that the Secretary of State should introduce measures to make such labelling a mandatory requirement for cigarettes sold or manufactured in the UK (paragraph 158).**

(hh) **We do not believe it would be appropriate for health policy to be shaped by the activities of criminal gangs. With this in mind we welcome the additional funding the Treasury is providing to boost Customs and Excise in their efforts to secure compliance with the law [in respect of smuggling of tobacco products into the UK] (paragraph 164).**

(ii) **We welcome the fact that the Government has launched its ambitious recent [tobacco education] campaign. We are not, however, convinced that the Government has enough knowledge of the reasons why people smoke to make such a campaign fully effective (paragraph 165).**

(jj) **We would draw the attention of health education authorities to the materials we have uncovered from the advertising agencies relating to the motivations of young and adult smokers. We believe that if this material were to be analysed carefully it could yield important information which could be used to dissuade people from smoking (paragraph 169).**

(kk) **We think it important that the information provided by public health authorities on cigarette packets, and given out in public health campaigns (in schools, workplaces, via primary care or through other media) adopts a greater variety of messages and conveys information not yet addressed in the health warnings. We believe that the general assertions that "smoking causes heart disease" or "smoking causes lung cancer", whilst having a place in an overall educational strategy, are not in themselves sufficient (paragraph 170).**

(ll) **We believe that the Department of Health should instigate a much more comprehensive and sophisticated educational programme. From our meetings with public health groups in America we think it is vital that young people should themselves be actively involved in dissuading their peers from smoking (paragraph 172).**

(mm) **We believe that messages for young people, who are often not impressed by arguments that their life will be shortened by smoking since death for them seems such a distant prospect, should range from information on the way smoking makes them less desirable socially to the ways in which tobacco makes poor people poorer. For example, the fact that smoking can damage skin and teeth should be made clear. There is also evidence that male potency can be damaged by smoking. This is a particularly strong message for young men and we recommend that the Government and health authorities make greater use of it when communicating the dangers of smoking. We further recommend that this message be included as one of the health warnings on packs (paragraph 172).**

(nn) **So far as adults are concerned, it is our view that the Department should take account of the fact that smoking is skewed towards those in poorer and less well educated households, as the advertising agencies do in many of their campaigns. We believe that the Department should examine the ways in which the agencies have marketed their advertising to this sector and copy some of their most successful strategies. We think it important that public health authorities, as well as conveying the risk of smoking attempt to convey the *magnitude* of the risks of smoking, in terms of stressing, for example, the numbers of years of life lost by an average smoker or the fact that smoking kills half of all lifelong smokers, and half of those before the age of 69. We think it important that adults should be much more aware of the benefits of quitting in respect of the surprisingly rapid health gains, not least in terms of the speedy improvement in likely life-expectancy that quitting yields. (Paragraph 173).**

(oo) **We believe it is essential that the packet contains clear and effective labelling to the effect that tobacco products are drug-delivery devices creating addiction through nicotine (paragraph 174).**

(pp) **We also believe that packs should have a contact number to gain access to NHS smoking cessation advice and programmes, (paragraph 174).**

(qq) **Messages should appear on *all* packs, stating the addictiveness of, and damage to health caused by smoking. In addition, a variety of health messages - such as that relating to male potency which we recommend above - should be used on certain packets. These messages should be harder hitting and more relevant to consumers than those currently used. (Paragraph 174).**

(rr) **If NRT is shown to increase smokers' motivations to quit, we believe the Government should consider making NRT available on prescription - available from smoking cessation clinics - for two weeks at a time, up to a maximum of six weeks in total. (Paragraph 180).**

(ss) **We believe that the Government is right to keep its distance from the tobacco industry which has, in our view, been the main beneficiary of the regime of voluntary agreements (paragraph 188).**

(tt) **The final conclusion of the RCP in its Report *Nicotine Addiction in Britain* was that "an independent expert committee should be established to examine the institutional options for nicotine regulation, and to report to the Secretary of State for Health on the appropriate future regulation of nicotine products and the management and prevention of nicotine addiction in Britain". We concur. It seems to us entirely illogical that treatments for nicotine replacement therapy are subject to stringent regulation whereas the infinitely more deadly tobacco products they are designed to supersede escape any fundamental regulation. So we believe a Tobacco Regulatory Authority (TRA) should be introduced (paragraph 189).**

(uu) **The proposed TRA could examine nicotine:tar ratios to determine how these could be optimised to minimise exposure to toxins (paragraph 191).**

(vv) **The TRA could consider the marketing of tobacco products, looking at areas of promotion going beyond advertising into issues such as point of sale displays (paragraph 192).**

(ww) **We think that technological means to make cigarettes safer and less addictive should be explored and that a TRA could provide the necessary impetus for this. The TRA could, we believe, profitably set upper limits, and progressive reductions for known carcinogens (paragraph 193).**

(xx) **We recommend that the UK should institute a TRA with responsibility for all aspects of tobacco regulation consistent with the limitations posed by EU law. We would eventually like to see a Europe-wide TRA, but we feel that such a body would have no credibility until such time as the CAP subsidy for tobacco growing is eliminated (paragraph 197).**

(yy) **We regard the current staff resources devoted to tobacco control, especially in the area of scientific knowledge and advice, to be pitifully weak. Irrespective of whether the Secretary of State accepts our recommendation that root and branch reform is needed in terms of a TRA, we would expect to see a major increase in resources, met out of the enormous income the tobacco companies pay in duties to the Treasury (paragraph 199).**

(zz) **We recommend that the Secretary of State makes immediate and urgent representations in Brussels to create a far more substantial unit to combat the enormous resources of the tobacco industry. We believe that European policy is already hugely compromised by the CAP subsidy, and that unless appropriate resources go into tobacco control European action in this sphere will lack credibility (paragraph 200).**

(aaa) **Gallaher's stance that they deplore smuggling appears to be contradicted by their advertising which seems to want to court those doing the smuggling. Gallaher noted in its evidence to us that smuggled tobacco gives children access to tobacco. If they genuinely believe that this and the other problems associated with smuggled tobacco are a "tragedy", they should make sure that all their business practices and those of their advertisers work against the illegal trade rather than encourage it (paragraph 207).**

(bbb) **We welcome the fact that BAT's audit committee will look into this matter [allegations of BAT involvement in smuggling] and we will be calling for its findings when they are available. But this is not enough. The allegations need to be looked at independently and we therefore call on the DTI to investigate them. If they prove to be substantiated, the case for criminal proceedings against BAT should be considered; if they prove to be false, then those perpetrating them should publicly apologise to BAT for what will have amounted to a malicious slur on the company's name (paragraph 222).**

(ccc) **We welcome the Framework Convention proposed by the World Health Organisation and the Government's support for it. However, any success will be dependent on a responsible approach being taken by the tobacco companies. Depressingly, there is little sign of that in the cheap jibes made at the WHO's expense by BAT. To call an organisation committed to improving global health 'zealots' and a 'super-nanny' because of its concern about the 10 million deaths which will be caused by tobacco each year by the late 2020s seems to us bizarre. We hope that the other companies - and, belatedly, BAT - will work constructively with the WHO. On a national level, we recommend that the Government requires the British tobacco companies to provide an annual summary of the action they have taken to co-operate with the WHO, to which the WHO should be invited to respond. If the action taken by the companies is not satisfactory, further action, including legislative and fiscal approaches, should be considered. It would be a hollow victory if, as a result of more stringent action taken on tobacco control in the developed world, smoking related deaths were merely exported to the world's poorer nations (paragraph 230).**

(ddd) **We believe that a commitment on the part of BAT to put all non-privileged documents held at Guildford on the internet, preferably in a searchable form, would indicate that it was serious in its attempts to "start the new millennium with a positive approach" to bringing an end to the allegations and arguments which have characterised relationships between public health authorities and the tobacco companies. At the very least, we believe BAT should automatically put all non-privileged documents which it has already scanned, or which it scans in the future, on the internet. Should BAT find this simple, and relatively cheap, option beyond it, the obvious inference should be drawn that they are resisting any attempts to have wider public access to this material.**

We regard BAT's limits of one organization, and a maximum of six visitors, per day to be indefensible. It seems to us that BAT is failing to enter into the spirit of the Minnesota agreement. Finally, we think that BAT should employ professionally qualified staff and up to date computers at Guildford - in this respect the contrast between the company's research and development facilities, with their highly qualified staff and state of the art equipment which we saw at Southampton, and the archive, with its untrained staff and slow computers, was stark (paragraph 241).

(eee) **We very much welcome the approach that Gallaher has taken to our request that it should make its archival material on the health risks of smoking publicly accessible. We believe that this represents a more mature response to the public health issues than has been evinced by UK companies in the past and that Gallaher should be commended for its responsible approach in this area (paragraph 243).**

(fff) **We believe that Imperial have adopted a reactionary and defensive posture. Their refusal to place in the public domain documents which may have a real bearing on the public health community's knowledge of the health risks of smoking seems to us lamentable (paragraph 245).**

MINUTES OF PROCEEDINGS RELATING TO THE REPORT

Monday 5 June 2000

Mr David Hinchliffe, in the Chair

Members present:

Mr David Amess	Mrs Eileen Gordon
Dr Peter Brand	Mr John Gunnell
Mr Simon Burns	Dr Howard Stoate

The Committee deliberated.

Draft Report, proposed by the Chairman (The Tobacco Industry and the Health Risks of Smoking), brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 247 read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.–(*The Chairman.*)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

Several Memoranda were ordered to be reported to the House.

[Adjourned till Thursday next at half-past Ten o'clock.

LIST OF REPORTS OF THE HEALTH COMMITTEE PUBLISHED DURING THE PRESENT PARLIAMENT

Session 1997–98

First Report: *Tobacco Advertising and the Proposed EC Directive* (HC 373) [Cm 3859]
Second Report: *Children Looked After by Local Authorities* (HC 319) [Cm 4175]
Third Report: *The Welfare of Former British Child Migrants* (HC 755) [Cm 4182]

Session 1998–99

First Report: *The Relationship between Health and Social Services* (HC 74) [Cm 4320]
Second Report: *Primary Care Groups* (HC 153) [Cm 4468]
Third Report: *Future NHS Staffing Requirements* (HC 38) [Cm 4379]
Fourth Report: *The Long Term Care of the Elderly* (HC 318) [Cm 4414]
Fifth Report: *Regulation of Private and Other Independent Healthcare* (HC 281) [Cm 4540]
Sixth Report: *Procedures related to Adverse Clinical Incidents and Outcomes in Medical Care* (HC 549) [Cm 4698]

Session 1999-2000

First Report: *The Cost and Availability of Generic Drugs to the NHS* (HC 105) [Cm 4673]

Note: [Cm ..] indicates the paper number of the Government Response

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